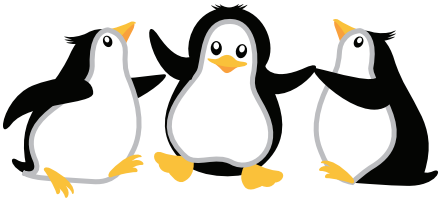

OBERLIN FAMILY DENTAL
Melanie B. Satterfield, DDS
General Dentist

WELCOME

542 W. Lorain Street
Oberlin, OH 44074
440-775-SMILE
440-775-7645
Fax 440-774-7645

We are please to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date _____
Name _____
Sex: ❑ Male ❑ Female ❑ Married ❑ Single ❑ Child ❑ Other
Birth Date _____ Social Security # ____-___-_____
Address _____ Email Address _____
City _____ State ____ Zip _____
Have we seen anyone in your household? Who _____
Home Phone (____)____-_____ Work # (____)____-_____ Cell # (____)____-_____
In case of emergency contact _____ (____)____-_____
Employer name _____ How did you hear about us? _____

PRIMARY DENTAL INSURANCE

Person responsible for the Account _____ Social Security # ____-___-_____
Address (if different from above) _____ City _____ State ___ Zip _____
Birth Date _____ Relation to Patient _____
Insurance Company _____ Group Plan _____ Employer _____
Insurance Address _____
City _____ State ____ Zip _____ Phone # (____)____-_____
Group # _____ Subscriber # _____

DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____
Former Dentist _____ Date of last dental x-rays _____
Check if you have had problems with any of the following:

☐ Bad Breath	☐ Grinding Teeth	☐ Sensitivity to Hot
☐ Bleeding Gums	☐ Loose Teeth or Broken Fillings	☐ Sensitivity to Sweets
☐ Clicking or popping jaw	☐ Periodontal Treatment	☐ Sensitivity when Biting
☐ Food collection between teeth	☐ Sensitivity to Cold	☐ Sores or Growths in your Mouth

How often do you floss? _____ How often do you brush? _____
Are you happy with your smile? _____ Have you ever whitened your teeth? _____
What would you change? _____ Are you interested in whitening? _____

OBERLIN DENTAL MEDICAL HISTORY FORM

Patient Name _____ Birth Date _____

Primary Care Physician _____ Date of last visit _____

Have you ever been hospitalized or had a serious illness? ☐ Yes ☐ No If yes, when _____

List any surgeries with years _____

_____

_____

List Medications or Supplements currently taking _____

_____

HABITS: Smoking: ☐ Currently Smoking ☐ Former Smoker ☐ Never Smoked

Smokeless Tobacco: ☐ Currently Using ☐ Formerly Used ☐ Never Used

Alcohol Consumption: Frequency & Amount _____

Do you use recreational drugs: ☐ Yes ☐ No

WOMEN ONLY: Are you pregnant ☐ Yes ☐ No If yes, due date _____ Nursing ☐ Yes ☐ No

ALLERGIES:

☐ Latex ☐ Penicillin ☐ Sulfa ☐ Other Antibiotics ☐ Local Anesthetic

☐ Aspirin ☐ Metals ☐ Codeine ☐ NSAIDs ☐ Other _____

CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING

☐ Heart Attack
☐ Congenital Heart Defect
☐ Irregular Heartbeat
☐ Angina/Chest Pains
☐ Heart Murmur
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Congestive Heart Failure
☐ Stent Placement
☐ Artificial Heart Valve
☐ Pacemaker
☐ By-Pass Surgery
☐ High Cholesterol
☐ ADD/ADHD
☐ Addiction Disorder
☐ Shortness of Breath
☐ Swelling of Ankles
☐ Anemia
☐ Sickle Cell Disease
☐ Hemophilia
☐ HIV/AIDS

☐ Buise Easily
☐ Prolonged Bleeding
☐ Tuberculosis
☐ Asthma
☐ Emphysema
☐ Lung Cancer
☐ Hard to Breathe Lying Down
☐ Persistent Cough
☐ Cough Up Blood
☐ Arthritis/Rheumatism
☐ Osteoporosis
☐ Gout
☐ Artificial Joints
☐ Kidney Disease
☐ Renal Diaysis
☐ STD's/Venereal Disease
☐ Stroke
☐ Severe Headaches/Migraines
☐ Fainting/Dizzy Spells
☐ Convulsions/Epilepsy
☐ Numbness/Tingling

☐ Diabetes Type I ☐ II ☐
☐ Excessive Thirst
☐ Thyroid Disease
☐ Hypogycemia
☐ Depression/Anxiety
☐ Psychiatric Treatment
☐ Glaucoma
☐ Tonsillitis
☐ Sinus Problems
☐ Hepatitis- Type ___
☐ Ulcers
☐ Crohn's Disease
☐ Cancer- Type _____
☐ Radiation Treatment
☐ Chemotherapy
☐ Organ Removal
☐ Organ Transplant
Other: _____
_____
_____
_____

To the best of my knowledge, all the above information is correct:

Signature: _____ Date: _____

If there is a credit of over $50.00 on your account, please check the box and initial with today's date your reimbursement preference.

☐ Please send a refund check for my credit balance to my address. *Initials* _____ *Date* _____

☐ Please leave the credit balance in my Oberlin Family Dental Account for future treatment. If credit is not used within 12 months from today, please send a refund check. *Initials* _____ *Date* _____