



Myrna Domoney, D.D.S., PLLC

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Berkshire Medical Plaza, Suite 101
918 / 250-0624

*Thank you for selecting
our dental healthcare team!
We will strive to provide you with
the best possible dental care. If you
have any questions, or need assistance,
please ask us - we will be happy to help.*

Patient Information (CONFIDENTIAL)

Date _____

Name _____ Birthdate _____ Soc. Sec. # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

E-mail Address _____ How would you prefer we contact you? _____

Marital Status Minor Single Married Divorced Widowed Separated Sex: Male Female

Patient's Employer (Name of School if Student) _____

Whom may We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

How would you prefer we contact you to confirm appointments? Cell Phone Home Phone Work Phone E-mail

Responsible Party

Check box if same as above.

Name of Person Responsible for Payment _____ Relationship to Patient _____

Birthdate _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____

Is this person currently a Patient in our Office? Yes No

*We will file with your insurance company as a courtesy to you; however, we cannot guarantee coverage for services.
We require payment in full of any portion estimated not to be covered by insurance on the date of service.
Please make arrangements, prior to your appointment date, if you need assistance with financial arrangements.*

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security Number _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Name of Employer _____

Insurance Company _____ Phone _____

Address _____ City _____ State _____ Zip _____

Policy # _____ Group # _____

Secondary Insurance Information (if applicable)

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security Number _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Name of Employer _____

Insurance Company _____ Phone _____

Address _____ City _____ State _____ Zip _____

Policy # _____ Group # _____

~ Over Please ~

Patient Medical History

Physician _____ Office Phone _____ Date of last Exam _____

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| <p>1. Are you under medical treatment now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you been hospitalized for any surgical operation(s) or serious illness within the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please explain _____</p> <p>3. Are you taking any Prescription Medication? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please list: _____</p> <p>4. Are you taking Non-Prescription Medicine or Vitamins? .. <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please list: _____</p> <p>5. Have you ever been told you need any pre-medication prior to dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>6. Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Are you wearing contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Are you allergic or have you had any reactions to the following?
 Local Anesthetics (e.g. Novocaine) <input type="checkbox"/> Yes <input type="checkbox"/> No
 Penicillin or any other Antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No
 Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No
 Codeine <input type="checkbox"/> Yes <input type="checkbox"/> No
 Iodine <input type="checkbox"/> Yes <input type="checkbox"/> No
 Latex Rubber <input type="checkbox"/> Yes <input type="checkbox"/> No
 Metals (e.g. nickel, mercury etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No
 Sedatives <input type="checkbox"/> Yes <input type="checkbox"/> No
 Sulfa Drugs <input type="checkbox"/> Yes <input type="checkbox"/> No
 Other (please list) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
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| <p>AIDS or HIV Infection <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Alzheimer's Disease / Dementia ... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Angina <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blood Transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Depression <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Easily Winded <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Epilepsy / Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Fainting / Convulsions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequent Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequent Heartburn/Acid Reflux <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequently Tired <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hay Fever / Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Disease / Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>HPV <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Irregular Heart Beat <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint Replacement or Implant ... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Kidney Diseases <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Radiation Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Recent Weight Loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Respiratory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sexually Transmitted Disease ... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swollen Ankles <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ever taken Phen-Fen/Redux <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Thyroid Problems/Disease <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
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Women Only:

Are you pregnant or think you may be pregnant? Yes ___ No ___ Are you nursing? Yes ___ No ___ Are you taking oral contraceptives? Yes ___ No ___

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

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| <p>1. Do your gums bleed while brushing or flossing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Are your teeth sensitive to hot or cold liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are your teeth sensitive to sweet or sour liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you feel pain to any of your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you have any sores or lumps in or near your mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you had any head, neck or jaw injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you experienced any of the following problems in your jaw?
 Clicking <input type="checkbox"/> Yes <input type="checkbox"/> No
 Pain (joint, ear, side of face) <input type="checkbox"/> Yes <input type="checkbox"/> No
 Difficulty in opening or closing <input type="checkbox"/> Yes <input type="checkbox"/> No
 Difficulty in chewing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>8. Do you have frequent headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you clench or grind your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Do you bite your lips or cheeks frequently? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Have you ever had any difficult extractions in the past? ... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Have you had any prolonged bleeding following extractions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Have you had any orthodontic treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Do you wear dentures or partials? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of placement _____</p> <p>15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Do you like your smile? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
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Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

We reserve the right to charge for appointments cancelled or broken without 48 hours advance notice!

Signature of Patient (Parent /Guardian) _____ Date _____