

# WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Corbyn L. Van Brunt, D.D.S. • 6565 S. Yale Ave. Suite 1103 • Tulsa, OK 74136 (918) 481-4910 • www.smilesoftulsa.com

## About You

Today's Date: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
**Name:** \_\_\_\_\_ I prefer to be called: \_\_\_\_\_  Male  Female  
Last First Mi Mr Mrs Ms Dr  
Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_  Single  Married  Divorced  Widowed  Separated  
**Home Address:** \_\_\_\_\_  
Street City State Zip  
Home Phone #: (\_\_\_\_) \_\_\_\_\_ Mobile/Pager #: (\_\_\_\_) \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_  
Where & when are best times to reach you? \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_  
Other family members seen by us: \_\_\_\_\_  
**Employer:** \_\_\_\_\_ How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
Street/PO Box City State Zip  
Responsible Party: \_\_\_\_\_

## Friend or Neighbor or Relative not living with you

His / Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_  
Street/PO Box City State Zip

So that we are able to suit your individual needs-which do you feel most applies to you:

### Check One:

- I want to maintain my teeth for a lifetime.
- It is not important to keep my teeth for a lifetime.

### Check One:

- I want the best dental care available for myself please recommend anything that you feel is necessary for good oral health.
- I want good dental care for myself, but there is a limit to what I am able to have done.
- I want you to perform only the services that I request.

### Check One:

- I want to learn as much as I can about dental health care, please explain in detail what has been done or what is needed.
- I would prefer you just summarize what has been done or what is needed.
- I want to be healthy, but don't need to know what has been done.

## Spouse Information

His / Her Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Mobile/Pager #: (\_\_\_\_) \_\_\_\_\_

## Dental History

**Why have you come to the dentist today?** \_\_\_\_\_

Are you currently in pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you require antibiotics before dental treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Your current dental health is	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Do you floss daily? <input type="checkbox"/> Yes <input type="checkbox"/> No	Brush daily? <input type="checkbox"/> Yes	<input type="checkbox"/> No	
Type of bristles on your toothbrush?	<input type="checkbox"/> Hard	<input type="checkbox"/> Medium	<input type="checkbox"/> Soft
Do your gums ever bleed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Ever Itch? <input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you ever had periodontal disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Are your teeth sensitive to heat, cold, or anything else? _____			

Do you have mobility in your teeth?  Yes  No  
Do you still have wisdom teeth?  Yes  No  
Previous / Present Dentist: \_\_\_\_\_ Last Visit Date: \_\_\_\_\_  
(Please Circle)  
Would you like fresher breath?  Yes  No Whiter teeth?  Yes  No  
**Are you happy with the way your smile looks?**  Yes  No  
If not, what would you change? \_\_\_\_\_  
Do you snore?  Yes  No  
Do you grind your teeth?  Yes  No

CONTINUED ON BACK

## Medical History

Do you have a personal physician?  Yes  No      Are you currently under the care of a physician?  Yes  No

Physician's Name: \_\_\_\_\_ Please explain: \_\_\_\_\_

Address: \_\_\_\_\_  
Street

\_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip

Phone #: (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_

**Your current physical health is:**  Good  Fair  Poor

Week #: \_\_\_\_\_ Are you nursing?  Yes  No

### Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Colitis	Y N Hay Fever	Y N Liver Disease	Y N Shingles
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Headaches	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Anemia	Y N Diabetes	Y N Heart Attack	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Murmur	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Heart Surgery	Y N Pacemaker	Y N Stroke
Y N Artificial Valves	Y N Emphysema	Y N Hemophilia	Y N Persistent Cough	Y N Thyroid Problems
Y N Asthma	Y N Epilepsy	Y N Hepatitis	Y N Psychiatric Problems	Y N Tonsillitis
Y N Blood Transfusion	Y N Ever Hospitalized	Y N Herpes	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Cancer	Y N Fainting Spells	Y N High Blood Pressure	Y N Rheumatic Fever	Y N Ulcers
Y N Chemotherapy	Y N Fever Blisters	Y N HIV+/AIDS	Y N Scarlet Fever	Y N Venereal Disease
Y N Chicken Pox	Y N Glaucoma	Y N Kidney Problems	Y N Seizures	

Please list any serious medical condition(s) that you have experienced: \_\_\_\_\_

Are you taking any prescription/over the counter drugs?  Yes  No If yes, please list each one:

RX	Reason Prescribed	RX	Reason Prescribed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### Are you allergic to any of the following?

Y N Aspirin	Y N Codeine	Y N Erythromycin	Y N Latex	Y N Sedatives	Y N Tetracycline
Y N Barbiturates	Y N Dental Anesthetics	Y N Jewelry / Metals	Y N Penicillin	Y N Sulfa Drugs	Y N Other

Please list anything additional that causes allergic reactions: \_\_\_\_\_

Premedication indicators:

Have you ever taken Phen-Fen, Redux or Pondimin?	Y N
Have you ever been diagnosed with a Heart Murmur?	Y N
Have you ever been diagnosed with Mitral Valve Prolapse?	Y N
Have you ever been diagnosed with Rheumatic Fever?	Y N
Have you had an artificial Pin, Joint, Or Shunt placed with the last 5 years?	Y N

### Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

\_\_\_\_\_  
Signature Date

### Medical History Update



CORBYN  
VANBRUNT  
D.D.S.

## First Appointment

You are very important to our office. We reserve two hours for your initial visit, to ensure that we can accurately assess your complete dental health. We want to provide you with the same quality of care that we demand for our own family and friends.

We understand that emergencies happen, however we have a cancellation policy. Please allow us at least 24 hours advance notice if you need to reschedule at a more convenient time. If last minute changes are necessary, the cancellation fee will be charged to your account.

Thank you for your consideration of this matter. We look forward to seeing you in our office soon.

## Appointment Cancellation Policy

Because of great patients like you, we are blessed with the gift of a growing practice. However, we don't want to lose our ability to schedule you quickly and conveniently. Effective immediately, we will be requiring that any appointment change be made at least 24 hours in advance of your scheduled time. Failure to do so will result in a \$72 cancellation fee.

We do not overbook our schedule and remain committed to the great deal of time Dr. VanBrunt and our hygienists spend with you. Through our mutual cooperation, we can both ensure you receive the highest care possible for which you are accustomed to receiving.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

*Family Dentistry To Smile About*

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