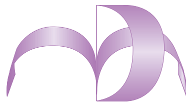

Myrna Domoney, D.D.S., PLLC

1621 South Eucalyptus Avenue • Broken Arrow, OK 74012
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 ____________

		Yes	No
1.	Are you under medical treatment now?	☐	☐
2.	Have you been hospitalized for any surgical operation(s) or serious illness within the last 5 years?	☐	☐
	If yes, please explain ____________		
3.	Are you taking any Prescription Medication?	☐	☐
	If yes, please list: ____________		
4.	Are you taking Non-Prescription Medicine or Vitamins?	☐	☐
	If yes, please list: ____________		
5.	Have you ever been told you need any pre-medication prior to dental treatment?	☐	☐
6.	Do you use tobacco?	☐	☐
7.	Are you wearing contact lenses?	☐	☐
8.	Are you allergic or have you had any reactions to the following?		
	Local Anesthetics (e.g. Novocaine)	☐	☐
	Penicillin or any other Antibiotics	☐	☐
	Aspirin	☐	☐
	Codeine	☐	☐
	Iodine	☐	☐
	Latex Rubber	☐	☐
	Metals (e.g. nickel, mercury etc.)	☐	☐
	Sedatives	☐	☐
	Sulfa Drugs	☐	☐
	Other (please list) ____________	☐	☐

	Yes	No
AIDS or HIV Infection	☐	☐
Alzheimer's Disease / Dementia	☐	☐
Anemia	☐	☐
Angina	☐	☐
Arthritis	☐	☐
Artificial Heart Valve	☐	☐
Asthma	☐	☐
Blood Transfusion	☐	☐
Bruise Easily	☐	☐
Cancer	☐	☐
Chest Pains	☐	☐
Chemotherapy	☐	☐
Depression	☐	☐
Diabetes	☐	☐
Easily Winded	☐	☐
Epilepsy / Seizures	☐	☐
Fainting / Convulsions	☐	☐
Frequent Headaches	☐	☐
Frequent Heartburn/Acid Reflux	☐	☐
Frequently Tired	☐	☐
Glaucoma	☐	☐
Hay Fever / Allergies	☐	☐
Heart Attack	☐	☐
Heart Disease / Trouble	☐	☐
Heart Murmur	☐	☐
Heart Pacemaker	☐	☐
Hepatitis	☐	☐
High Blood Pressure	☐	☐
HPV	☐	☐
Irregular Heart Beat	☐	☐
Jaundice	☐	☐
Joint Replacement or Implant	☐	☐
Kidney Diseases	☐	☐
Leukemia	☐	☐
Liver Disease	☐	☐
Low Blood Pressure	☐	☐
Mitral Valve Prolapse	☐	☐
Psychiatric Care	☐	☐
Radiation Therapy	☐	☐
Recent Weight Loss	☐	☐
Respiratory Problems	☐	☐
Rheumatic Fever	☐	☐
Sexually Transmitted Disease	☐	☐
Stroke	☐	☐
Swollen Ankles	☐	☐
Ever taken Phen-Fen/Redux	☐	☐
Thyroid Problems/Disease	☐	☐
Tuberculosis	☐	☐
Ulcers	☐	☐
Other ____________	☐	☐

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 ____________

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

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 ____________