DR. CARBERY'S
OASIS DENTAL

(509) 966-4220
1015 South 40th Avenue, Suite #19
Yakima, Washington 98908

Patient Information

Date _____

Patient's Name _____ (Last) _____ (First) _____ (Middle)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

SSN: _____ Birthdate _____ Home Phone _____ Cell Phone _____

E-Mail Address: _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name _____ (Last) _____ (First) _____ (Middle)

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

No. years at this address _____ Home Phone _____ Work Phone _____ Cell Phone _____

Previous Address (if less than 2 yrs.) _____ (Street)

_____ (City) _____ (State) _____ (Zip Code)

SSN: _____ Birthdate _____ Relationship to Patient _____

Driver's License # _____

Employer _____ Occupation _____ No. Years employed _____

Spouse's Name _____ (Last) _____ (First) _____ (Middle)

Spouse's Employer _____ Spouse's SSN: _____

Occupation _____ No. Yrs. Employed _____ Work Phone _____

Insurance Information

Do you have Dental Insurance? Yes ☐ No ☐ If no, Signature _____

Insured's Name _____ Insured's SSN: _____

Primary
Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Birthdate _____ Dual Coverage Yes ☐ No ☐

Insured's Name _____ Insured's SSN: _____

Secondary
Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____ Insured's Birthdate _____

I will be responsible for the total costs regardless of insurance reimbursement. I authorize Dr. Carbery or any collection agencies used by Dr. Carbery to contact me by my cell phone for billing activities or payment arrangements.

Please indicate how you would like to pay for your service ☐ Cash ☐ Check ☐ Visa / MC

I understand that a credit report may be obtained.

Signature (or Legal Guardian) _____

Date _____

	Yes	No
Have you been examined and/or treated by a physician within the last year?	☐	☐
Are you taking medicines now?	☐	☐

What:_____

Physicians Name:

_____

Phone number:

_____

Have you been:

	Yes	No
1. Seriously ill Explain:_____	☐	☐
2. Hospitalized	☐	☐
3. Treated with radiation or cobalt for tumors What area(s):_____	☐	☐
4. Told you have a heart murmur When:_____	☐	☐

Have you had:

	Yes	No
5. Major surgery Explain:_____ Date _____	☐	☐
6. Blood transfusion	☐	☐
7. Rheumatic fever	☐	☐
8. Inflammatory rheumatism	☐	☐
9. Yellow jaundice/hepatitis	☐	☐
10. Tuberculosis	☐	☐
11. Venereal disease	☐	☐
12. Heart attack	☐	☐
13. Stroke	☐	☐
14. Hives, skin rash	☐	☐
15. Asthma	☐	☐
16. Cancer Explain:_____ Date of surgery:_____	☐	☐
17. Diabetes (sugar disease)	☐	☐
18. Injury to face or jaw	☐	☐
19. Allergies If yes, to what:_____	☐	☐
20. Aids	☐	☐
21. Artificial joints, screws, rods, etc (if yes) type/date of surgery _____ Orthopedic surgeon/phone/name _____	☐	☐

Have you had unusual reaction to any of these?	Yes	No
22. Dental anesthesia	☐	☐
23. Aspirin	☐	☐
24. Penicillin	☐	☐
25. Iodine	☐	☐
26. Sleeping pills	☐	☐
27. Latex	☐	☐
28. Other:_____		

Hematology - Do you:

29. Bleed a long time after an injury	☐	☐
30. Bruise easily	☐	☐
31. Have blood disorders, anemia, thin blood	☐	☐

Head - Do you have:

32. Severe headaches	☐	☐
33. Eye trouble	☐	☐
34. Sinus trouble	☐	☐
35. Frequent nosebleeds	☐	☐
36. Sensitive teeth	☐	☐
37. Aching teeth	☐	☐
38. Bleeding gums	☐	☐
39. Sore gums or mouth	☐	☐
40. Frequent canker sores/ cold sores/fever blisters	☐	☐
41. Sore jaw muscles	☐	☐
42. Ear aches	☐	☐
43. Difficulty opening mouth wide	☐	☐

Cardiorespiratory - Do you:

44. High/Low blood pressure	☐	☐
45. Shortness of breath	☐	☐
46. Chest pains	☐	☐
47. Swollen ankles	☐	☐
48. Persistent cough	☐	☐
49. Blood sputum produced by coughing	☐	☐

Gastrointestinal - Have you had:

50. Recent change of appetite	☐	☐
51. Food that you cannot eat	☐	☐
52. Difficulty in swallowing	☐	☐
53. Frequent indigestion	☐	☐
54. Frequent vomiting	☐	☐

Genitourinary - Do you:

55. Feel thirsty much of the time	☐	☐
56. Urinate more than 6 times a day	☐	☐
57. Have kidney trouble	☐	☐

Neuromuscular - Skeletal - Do you have:	Yes	No
58. Painful, swollen joints	☐	☐
59. Numb or pricking sensations on skin	☐	☐
60. A history of broken bones What:_____ When:_____	☐	☐
61. A tendency to faint	☐	☐
62. Fits or convulsions	☐	☐

Habits - Disease:
Do you consistently use:

63. Tobacco	☐	☐
Would you like to quit	☐	☐
64. Alcoholic beverages	☐	☐
65. Drugs:_____	☐	☐
66. Received or receiving treatment in a drug or alcohol center	☐	☐

Women Only - Are:

67. You now pregnant	☐	☐
68. You going through menopause	☐	☐
69. You passed menopause	☐	☐

Children Only:

70. Has the child experienced an unfavorable reaction from medical or dental treatment	☐	☐
71. I authorize Dr. Carbery to administer nitrous oxide sedation to my child	☐	☐
Do we need permission from parent at each appointment	☐	☐

Emergency Contact:

Name:_____

Phone Number:_____

Signature_____

Parent's signature if minor_____

For office use only.