Oasis Dentistry – Gwen Huynh, DMD

New Patient Information

10184 W. Happy Valley Pkwy, Suite 195, Peoria, AZ 85383
Phone (623) 486-2640 Fax (623) 566-4727

A personal, comfort focused approach to dental health...

Welcome to our practice.

Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Patient Information

Patient Number_____

Today's Date _____

First Name _____ Middle Initial _____ Last Name _____

I prefer to be called (nickname, etc.) _____ ☐ Male ☐ Female

Address _____ City _____ State _____ Zip _____

Date of Birth_____ Social Security No._____

Home Phone (____)_____-_____ Work Phone (____)_____-_____ Cell Phone (____)_____-_____

Primary contact number (please check one) ☐ Home ☐ Work ☐ Cell Best time to call _____

Fax (____)_____-_____ E-mail_____ Driver's License No. _____

Employer _____ Occupation _____

Spouse's Name _____ Spouse's Employer _____

Whom may we thank for referring you? _____

If the patient is a child:

School _____ School Phone (____)_____-_____ Grade _____

Dental History

Reason for today's visit _____

Are you currently in pain? ☐ Yes ☐ No

If so, please describe: _____

Do you have any dental problems now? ☐ Yes ☐ No

If so, please describe: _____

Have you ever had trouble with a previous dental treatment? ☐ Yes ☐ No

If so, please describe: _____

Level of anxiety about seeing the dentist: (least) 1 2 3 4 5 (most)

Date of last dental exam _____ Date of lasting cleaning _____ Date of last full month X-rays _____

Procedure(s) done at last dental visit _____

Previous Dentist's Name _____

City _____ State _____ Phone (_____)_____-_____

Why are you changing dentists? _____

How often do you have dental examinations? _____ How often do you brush your teeth?_____

How often do you floss? _____ What type of bristles do you use? ☐ Hard ☐ Medium ☐ Soft

Do you require antibiotics before dental treatment?	☐ Yes	☐ No	Do you have frequent headaches?	☐ Yes	☐ No
Do your gums ever bleed?	☐ Yes	☐ No	Do you clench or grind your teeth?	☐ Yes	☐ No
Have you noticed any mouth odors or bad tastes?	☐ Yes	☐ No	Are your teeth sensitive to heat/cold?	☐ Yes	☐ No
Do you bite your lips or cheeks frequently?	☐ Yes	☐ No	Do you still have your wisdom teeth?	☐ Yes	☐ No

Oasis Dentistry – Gwen Huynh, DMD

New Patient Information

10184 W. Happy Valley Pkwy, Suite 195, Peoria, AZ 85383
Phone (623) 486-2640 Fax (623) 566-4727

A personal, comfort focused approach to dental health...

Have you ever had:

Periodontal disease/gum treatment	☐ Yes ☐ No		Discomfort in your jaw joint (TMJ/TMD)	☐ Yes ☐ No	
Orthodontics Treatment	☐ Yes ☐ No		Your teeth ground or bit adjusted	☐ Yes ☐ No	
Oral Surgery	☐ Yes ☐ No		Serious injury to the mouth or head	☐ Yes ☐ No	
A bit plate or mouth guard	☐ Yes ☐ No				

If yes to any of the previous questions, please describe: _____

_____

If there anything else about your past dental treatment(s) that you would like us to know? _____

_____

Medical History

Have you been hospitalized or under the care of a medical doctor during the past 2 years? ☐ Yes ☐ No

If yes, for what? _____

Hospital or Physician's Name _____ Phone (_____)_____-_____

Hospital or Physician's City _____ State _____

Have you taken any medications or drugs in the past two years? ☐ Yes ☐ No

Are you currently taking any medications or drugs? (including regular doses of aspirin or over-the-counter medicines? ☐ Yes ☐ No

If yes, please explain _____

Have you every taken Fen-Phen? ☐ Yes ☐ No

If so, how long ago? _____

Have you been to the doctor to check for heart problems? ☐ Yes ☐ No

If so, what are the problems? _____

Do you use tobacco? ☐ Yes ☐ No **Do you use alcohol or any other controlled substance?** ☐ Yes ☐ No

Women only:

Are you pregnant or think you may be pregnant?	☐ Yes ☐ No	Are you nursing?	☐ Yes ☐ No
Are you taking birth control pills?	☐ Yes ☐ No		

Indicate which of the following you have had or have at present:

AIDS/HIV	☐ Yes ☐ No	Difficulty Breathing	☐ Yes ☐ No	Lupus	☐ Yes ☐ No
Alcohol/Drug Abuse	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Allergies or Hives	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	Nervousness/Anxiety	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or Dizzy Spells	☐ Yes ☐ No	Neurological Disorders	☐ Yes ☐ No
Arthritis/Rheumatism	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Psychiatric/	
Artificial Heart Valve	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Psychological Care	☐ Yes ☐ No
Artificial Bone/Joints	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Radiation Therapy	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart (Surgery Disease,		Rheumatic/Scarlet Fever	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Attack)	☐ Yes ☐ No	Shingles/Chicken Pox	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Sickle Cell Disease/Traits	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Cancer/Chemotherapy	☐ Yes ☐ No	Hemophilia/Abnormal		Snoring/Sleep Apnea	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No	Bleeding	☐ Yes ☐ No	Stomach Problems/Ulcers	☐ Yes ☐ No
Cold Sores/Herpes	☐ Yes ☐ No	Hepatitis A B C (circle)	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Colitis	☐ Yes ☐ No	High or Low Blood Pressure	☐ Yes ☐ No	Swollen Ankles	☐ Yes ☐ No
Contact Lenses	☐ Yes ☐ No	Hospitalized for Any Reason	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Cortisone Medicine	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Tuberculosis (TB)	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Kidney Trouble	☐ Yes ☐ No	Tumors	☐ Yes ☐ No
Diet (Special/Restricted)	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Venereal Disease/STD	☐ Yes ☐ No

Please list any serious medical condition(s) that you have ever had not listed above:

_____

Are you aware of having an allergic (or adverse) reaction to any of the following:

Aspirin	☐ Yes ☐ No	Iodine	☐ Yes ☐ No	Sedatives	☐ Yes ☐ No
Codeine	☐ Yes ☐ No	Jewelry/Metals	☐ Yes ☐ No	Sulfa Drugs	☐ Yes ☐ No
Anesthetics (ie-Novocaine)	☐ Yes ☐ No	Latex	☐ Yes ☐ No	Tetracycline	☐ Yes ☐ No
Erythromycin	☐ Yes ☐ No	Penicillin or Other Antibiotics	☐ Yes ☐ No	Other _____	

Patient Signature_____

Oasis Dentistry – Gwen Huynh, DMD
Financial Policy

10184 W. Happy Valley Pkwy, Suite 195, Peoria, AZ 85383
Phone (623) 486-2640 Fax (623) 566-4727
A personal, comfort focused approach to dental health...

Thank you for choosing Oasis Dentistry for your dental needs. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of this mission is making the cost of optimal care manageable for our patients by offering several payment options.

Payment Options:

We accept: Visa, MasterCard, American Express, Cash or Check

We offer: Convenient Monthly Payment Plans[1] from CareCredit

This allows you to pay over time with no annual fees or pre-payment penalties

Please note:

Oasis Dentistry requires payment at the time services are rendered. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For patients with dental insurance we are happy to work with your carrier to maximize your benefits. We will bill them directly for payment of the services you recieve.[2]

A fee of $35.00 is charged to patients who miss or cancel without a 48-hour notice.

A fee of $25 is charged to patients for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and need.

_____

Patient/Guardian Signature *Date*

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.