Welcome to Oakland City Dental

Dental Registration and History

Dr Dahab Gaime
2844 Summit St. Suite 208
Oakland, CA 94609
(510) 444-0971
oaklandcitydental.com

1. PATIENT INFORMATION

Patient Name _____ _____
Last Name First Name Middle Initial

Date _____ Birthday _____

SS# or Insurance ID# _____ Sex ☐M ☐F

Address _____

City _____ State _____ Zip _____

Home Tel _____ Work Tel _____

Mobile # _____ Occupation _____

Email _____ Marital Status _____

Referral Source _____

Notes _____

2. EMPLOYER / SCHOOL

Employer/ School Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

Notes _____

3. EMERGENCY CONTACT

Emergency Contact Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Relationship _____

4. INSURANCE INFORMATION

Responsible Party Name _____

Relationship to Patient _____

Insurance Company _____

Subscriber Name _____

Group # _____ SS# _____

Birthday _____ Other Coverage ☐ Yes ☐ No

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with:

_____

and assigned directly to Dr _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature _____ Date _____

5. DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ Tel _____ Last X-Ray Date _____

Last Cleaning _____ Last Dental Visit _____

Do you feel pain ☐Yes ☐No if yes please describe _____

Do you feel numbness, swelling, or any other sensitivity? ☐Yes ☐No if yes please explain _____

_____

Additional comments about your past dental history _____

_____

Reset Form

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6. HEALTH HISTORY

Physician Name _____ Physician Tel _____

Have you ever taken any of the group of drugs collectively referred to as "Fen-Phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentennine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ ☐ No	Sinus Trouble	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type __	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
		Do you wear contact lenses?	☐ Yes ☐ No		

Women: Are you pregnant? ☐ Yes ☐ No If yes due date: _____ Are you nursing? ☐ Yes ☐ No

7. MEDICATION & ALLERGIES

Please list all the medication you are currently taking _____

_____

_____

_____

Please list any known allergies _____

_____

Are you allergic to any of the following? ☐ Yes ☐ No

If yes please circle: Aspirin, Barbiturates (Sleeping pills), Codeine, Iodine, Latex, Local Anesthetic, Penicillin

Any other allergies? ☐ Yes ☐ No

8. UPDATES (for future visits)

Date _____

Changes to medical history _____

_____

Patient Signature _____

Doctor Signature _____

Date _____

Changes to medical history _____

_____

Patient Signature _____

Doctor Signature _____

Reset Form Print Form