Welcome to our Practice

Tamarack Dental Associates

Dr. Mark Goodman Dr. Nathan Talley Dr. Jacob Cary

801 E. Tamarack Rd 580-482-5424

PATIENT INFORMATION

Name_______________________________ Soc. Sec. #______________
Last name First name Initial

Address_______________________________

City______________ State________ Zip________ Home Phone______________

Sex M F Age_____ Birthdate __________ Single Married Widowed Separated Divorced

Patient Employed by ______________________ Occupation ______________

Business Address ______________________ Business Phone______________

Whom may we thank for referring you? ______________________

Notify in case of emergency ______________________ Home Phone______________

Cell Phone______________________

I consent to Tamarack Dental Associates, or its service provider, using my current or future cell phone number and email address to (choose one or both) ☐ Call or ☐ text regarding appointments and health care information such as treatment, insurance, and my account. I understand that I can withdraw my consent at any time. My cell phone number is (include area code) ______________ Email ______________

Signature ______________________ Date ______________

PRIMARY DENTAL INSURANCE

Person Responsible for Account______________________
Last Name First Name Initial

Relation to Patient______________ Birthdate __________ Soc Sec. # ______________

Address (if different from patient)______________________ Home Phone______________

City______________ State________ Zip________ Cell Phone______________

Employed by ______________________ Occupation______________

Insurance Company______________________ Phone______________

Group # ______________________ Subscriber ID#______________

Name of other dependents under this plan ______________________

Please notify us if you have a secondary insurance.

Tamarack Dental Associates, PLLC

Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medications that you may be taking could have an important interrelationship with the dentistry you will receive.

Dental History

Are you in dental discomfort today? Yes No

Former Dentist/Phone Number: If yes

Date of last dental care/xrays If yes

Are you experiencing issues with:

Bad Breath	Yes No	Food collection between teel	Yes No	Sensitivity to cold	Yes No
Bleeding Gums	Yes No	Grinding/clenching	Yes No	Sensitivity to hot	Yes No
Clicking or popping jaws	Yes No	Loose teeth/broken fillings	Yes No	Sensitivity to sweets	Yes No
Dental Anxiety	Yes No	Periodontal treatment	Yes No	Sores or growths in mouth	Yes No

Are you under a physician's care now? Yes No If yes

Have you ever been hospitalized, had a major operation, or serious neck or head injury? Yes No If yes

Are you taking any medications? Yes No If yes

Are you taking blood thinners? (Coumadin, Plavix, Aspirin, Vitamin E, Gingko Biloba, Aggrenox, Yes No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin	Penicillin	Codeine	Acrylic
Metal	Latex	Sulfa Drugs	Local Anesthetics

Other? If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Emphysema	Yes No	Leukemia	Yes No
Alzheimer's Disease	Yes No	Fainting	Yes No	Liver Disease	Yes No
Anaphylaxis	Yes No	Glaucoma	Yes No	Low Blood Pressure	Yes No
Anemia	Yes No	Hay Fever	Yes No	Lung Disease	Yes No
Arthritis	Yes No	Heart Attack/Failure	Yes No	Psychiatric Care	Yes No
Artificial Joint	Yes No	Heart Murmur	Yes No	Radiation Treatment	Yes No
Asthma	Yes No	Pacemaker	Yes No	Rheumatic/Scaret Fever	Yes No
Back Problems	Yes No	Heart Trouble/Disease	Yes No	Shingles	Yes No
Blood Transfusion	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Cancer	Yes No	Mitral Valve Prolapse	Yes No	Spina Bifida	Yes No
Chemical Dependency	Yes No	Hepatitis A	Yes No	Swelling of Limbs	Yes No
Chemotherapy	Yes No	Hepatitis B	Yes No	Tobacco Habit	Yes No
Cold Sores/Fever Blisters	Yes No	Hepatitis C	Yes No	Thyroid Disease	Yes No
Convulsions	Yes No	High Blood Pressure	Yes No	Tonsillitis	Yes No
Cortisone Medicine	Yes No	Hives or Rash	Yes No	Tuberculosis	Yes No
Cough, Persistent	Yes No	Hypoglycemia	Yes No	Tumors/Growths	Yes No
Diabetes	Yes No	Kidney Problems	Yes No	Ulcers/Colitis	Yes No

Signature of Patient, Parent or Guardian:

X

Date:__________