DR. ROY OYANGEN
ADVANCED AESTHETICS DENTISTRY . COM

Although dental professionals treat areas in and around the mouth, your mouth is part of your entire body. Health problems that you have or medications that you may be taking could have an important inter relationship with the dental procedure you will be receiving.
Thank you for answering the following questions.

Patient Name: ______________________ **Date of Birth:** ____ / ____ / ______
MM DD YYYY

Best Daytime Contact # : H / W / C ______________________ **Email:** ______________________

Allergies to any Drugs / Environmental / Food? **No**___ **Yes**___ **Please List them...** ______________________

____

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Allergic to Latex? **No**______ **Yes**______

Have You Been Told By A Physician To Take Antibiotics Before A Dental Visits? **No** ______ **Yes**_______

If Yes, For What?______________________

List Your Medications / Vitamins (Even O.T.C.)?______________________

____

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Your Medical History; Please Check ALL That Apply:

- ___ Heart Disease
- ___ Heart Attack, Date______________
- ___ Heart Surgery, Date______________
- ___ Heart Pace Maker
- ___ Pulmonary Shunt / Stent
- ___ Mitral Valve Prolapse
- ___ High / Low Blood Pressure
- ___ Congenital Heart Disease
- ___ Stroke
- ___ Asthma
- ___ C.O.P.D. / Emphysema
- ___ Lung Disease
- ___ Cancer / Tumors
- ___ Chemotherapy / Radiation
- ___ Diabetes
- ___ Excessive Thirst
- ___ Hypoglycemia
- ___ Hepatitis (A/B/C)
- ___ Rheumatic or Scarlet Fever
- ___ Thyroid Disease
- ___ Liver Disease
- ___ Tuberculosis
- ___ Alzheimer’s Disease
- ___ Glaucoma
- ___ Arthritis / Gout
- ___ Cortisone / Steroid Medications
- ___ Fosamax / Actonel / Boniva
- ___ Osteonecrosis Of The Jaw
- ___ Artificial Joint Replacement, Date______________
- ___ Anemia / Bruising Easily
- ___ Blood Transfusions
- ___ Blood Disease / Disorder
- ___ Leukemia
- ___ Neurological Disorder
- ___ Cold Sores / Fever Blisters / Canker Sores
- ___ HIV or Human Papillomavirus Positive
- ___ Sexually Transmitted Disease (STD)
- ___ Tattoo / Body Piercing
- ___ Drug Dependency / Alcoholism
- ___ Tobacco Use / Vaping
- ___ Psychiatric Care
- ___ Anxiety / Depression
- ___ Stomach GERD
- ___ Ulcers
- ___ Recent Weight Loss / Gain
- ___ Frequent Diarrhea / Intestinal Disorders
- ___ Celiac / Crones Disease
- ___ Headaches / Migraines
- ___ Epilepsy / Seizures
- ___ Fainting or Dizziness

Any Recent Surgeries or Hospitalization? **No** ___ **Yes** ___ **When:** ______________ **Why?** ______________

____

Women: Taking Birth Control ____ Nursing ____ Pregnant or Trying? ____

Primary Physician’s Name: ______________________ **Phone:** ______________

Address:______________________

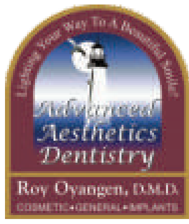
Date of Last Visit? ______________

Cardiologist’s Name: ______________________ **Phone:** ______________

Address:______________________

Date of Last Visit? ______________

Reviewed By: ________ Date: ________



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113 Saratoga Rd Schenectady (Glenville) NY 12302

PATIENT NAME: ____________________ **Date Of Birth:** ____ / ____ / ______
MM DD YYYY

REASON FOR THIS APPOINTMENT: Exam Emerg Consult Other

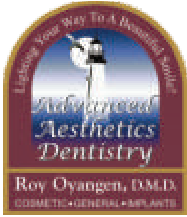
DENTAL HISTORY

	Check One: Yes	No
Do You Have A Specific Dental Problem? Describe...		
Do You Have Routine Dental Checkups? Last Visit?		
Do You Brush And Floss On A Routine Basis?		
Do Your Gums Bleed When Brushing / Flossing?		
Does Food Catch Between Your Teeth?		
Do You Have Any Loose Teeth?		
Do You Grind Your Teeth?		
Do You Ever Have Clicking, Popping, Or Discomfort In Your Jaw?		
Do You Have Frequent Headaches / Neck Pain?		
Have You Had Any Head, Neck, or Jaw Injuries?		
Have Any Difficulty Opening or Closing Your Mouth?		
Have Difficulty Chewing?		
Do You Wear Dentures or Partials?		
Do You Breathe Through Your Mouth While Awake or Asleep?		
Do You Snore or Stop Breathing at Night?		
Have You Had An Oral Cancer Screening? When?		
Do You Want To Keep Your Remaining Teeth?		
Do You Like Your Smile?		

Authorization:

I hereby authorize payment directly to the dental office for the group insurance otherwise payable to me. I understand I am responsible for all the costs of dental treatment. I hereby authorize the dental office to administer such medications and perform diagnostic photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical / dental histories is correct to the best of my knowledge. I grant the right to the dentist to release my dental / medical information and information about my dental treatment to third party payors and other health care professionals by any method including electronic transfer.

Patient Signature: ______________________________ **Today's Date:** ____ / ____ / ______
MM DD YYYY



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PATIENT INFORMATION

FIRST LAST M.I. **Date Of Birth:** MM / DD / YYYY

STREET CITY STATE ZIP + 4

HOME # WORK # CELL #

E-MAIL

EMPLOYER'S NAME:

SOCIAL SECURITY #

REFERRED BY:

Emergency Contact

Relationship

Daytime Contact #

E-MAIL

PRIMARY INSURANCE /

If No Insurance; Please Check Here:_____

(Completed by Responsible Party)

Dental Insurance Company

Name of Policy Holder

Employer

Date Of Birth MM / DD / YYYY

Subscriber #

Group #

Social Security Or ID #

Relationship To Patient

SECONDARY INSURANCE

Dental Insurance Company

Name of Policy Holder

Employer

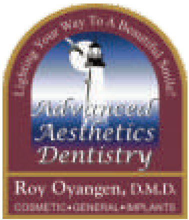
Date Of Birth MM / DD / YYYY

Subscriber #

Group #

Social Security Or ID #

Relationship To Patient



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NO SHOW, MISSED APPOINTMENT OFFICE POLICY

When our office works with you to set up your appointment date, we are setting aside a dedicated amount of time in the chair for you Every patient in our practice receives this unique reservation. When your appointment is made, a time is reserved, your materials are ordered and we make special arrangements to be ready for you visit. Except for emergency treatment for another patient from time to time, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

If you feel you must reschedule your appointment, we ask that you provide us with at least a **24** hour notice.

This courtesy makes it possible to give your reserved time to another patient who would be more than happy to accept that appointment time.

REPEATED CANCELLATIONS OR MISSED APPOINTMENTS WILL RESULT IN LOSS OF FUTURE APPOINTMENT PRIVILEDGES

PLEASE BE ADVISED OF THE FOLLOWING

*THERE IS A FEE OF **$50.00** FOR NOT SHOWING UP FOR A SCHEDULED APPOINTMENT

*THERE IS A FEE OF **$35.00** FOR A RETURNED CHECK

**** ANY APPOINTMENT SCHEDULED FOR TWO HOURS OR LONGER MUST BE **PAID IN FULL PRIOR** TO SUCH AN APPOINTMENT. THIS ALSO INCLUDES ANY ORAL CONSCIOUS SEDATION APPOINTMENTS***

CANCELLATION OF THESE TYPE OR APPOINTMENTS WITHOUT **48** HOURS NOTICE WILL RESULT IN A CHARGE OF **10%** OF YOUR TOTAL APPOINTMENT FEE.

Any of the above fees that have been placed on your account must be paid in **FULL** prior to any future appointments. We thank you for your understanding and allowing us to provide your dental care.

Dr. OYANGEN and TEAM