## PATIENT INFORMATION

NAME_____ DATE OF BIRTH_____ SEX_____

MARITAL STATUS_____ SSN_____ HOME PHONE_____ CELL_____ WORK_____

ADDRESS_____ CITY_____ STATE_____ZIP_____

EMAIL_____ EMPLOYER/SCHOOL_____

EMERGENCY CONTACT_____ RELATIONSHIP TO PATIENT_____ PHONE_____

PHYSICIAN_____ PHONE NUMBER_____ PHARMACY_____

## DENTAL INSURANCE

*As a courtesy to our patients, we will be happy to file your dental insurance for your services provided at this office. After 60 days, if your insurance has not paid, or has not paid in full, you are responsible for full payment of your balance. Please provide any secondary insurance on reverse.*

INSURANCE CO_____ ADDRESS_____

NAME OF INSURED_____ INSURED SSN_____ INSURED DATE OF BIRTH_____

GROUP #_____ INSURED'S EMPLOYER_____ INSURANCE PHONE #_____

## MEDICAL HISTORY

*Information about your health will be held as confidential by this office and will be released only upon your request.*

1. YES☐ NO☐ Have you been treated by a doctor, or have you been in the hospital in the last two years?

IF YES WHY?_____

2. YES☐ NO☐ Are you taking any medications at this time?

PLEASE LIST_____

3. YES☐ NO☐ Have you ever had an allergic or unusual reaction to any medications?

PLEASE LIST_____

4. YES☐ NO☐ Do you have any other allergies that you know of?

PLEASE LIST_____

5. Have you had or do you presently have any of the following conditions?

YES☐ NO☐ HEART ATTACK, DISEASE OR SURGERY

YES☐ NO☐ ANGINA OR CHEST PAINS

YES☐ NO☐ HEART MURMUR

YES☐ NO☐ MITRAL VALVE PROLAPSE

YES☐ NO☐ ARTIFICIAL HEART VALVE

YES☐ NO☐ HEART PACEMAKER

YES☐ NO☐ SMOKE

YES☐ NO☐ KIDNEY DISEASE

YES☐ NO☐ EPILEPSY

YES☐ NO☐ LUNG DISEASE INCLUDING TUBERCULOSIS

YES☐ NO☐ HIGH BLOOD PRESSURE

YES☐ NO☐ ARTIFICIAL JOINT

YES☐ NO☐ BLOOD DISEASE

YES☐ NO☐ EXCESSIVE BLEEDING/BRUISE EASILY

YES☐ NO☐ EXCESSIVE THIRST

YES☐ NO☐ CANCER

YES☐ NO☐ PAIN IN JAW JOINTS

YES☐ NO☐ DIABETES

YES☐ NO☐ CHEMOTHERAPY OR RADITION TREATMENT

YES☐ NO☐ HEPATITIS, JAUNDICE, OR LIVER DISEASE

YES☐ NO☐ AIDS OR HIV POSITIVE

YES☐ NO☐ SEXUALLY TRANSMITTED DISEASE

YES☐ NO☐ OTHER INFECTIOUS DISEASE (STAPH, MRSA, ETC.)

YES☐ NO☐ ASTHMA

YES☐ NO☐ STOMACH OR INTESTINAL ULCERS/DISEASE

YES☐ NO☐ HAY FEVER OR SINUS TROUBLE

YES☐ NO☐ THYROID DISEASE

YES☐ NO☐ DRUG OR ALCOHOL PROBLEM

YES☐ NO☐ ARTHRITIS

YES☐ NO☐ LEUKEMIA

YES☐ NO☐ EASILY WINDED

YES☐ NO☐ HIGH CHOLESTEROL

YES☐ NO☐ OSTEOPOROSIS

YES☐ NO☐ PSYCHIATRIC CARE

OTHER/COMMENTS_____

6. YES☐ NO☐ Are you currently taking, or have you taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?

7. WOMEN: Are you pregnant, nursing, or do you think you may be pregnant? YES☐ NO☐

**CLICK HERE TO PRINT FORM, SIGN, AND DATE**