

PATIENT INFORMATION (Please Print)

NAME Dr. Mr. Mrs. Ms. _____
Last First Middle

Child Single Married Age _____ Date of Birth _____

Home Address _____ City _____ State _____ Zip _____

Mailing Address if Different _____

Home ☎ _____ Business ☎ _____ Ext. # _____ Social Security# _____

Employer _____ Occupation _____

Guardian / Spouse's Name _____ Person Responsible for Bill _____

Dental Insurance Yes No If Yes Group Carrier _____ Group# _____

Name of Primary Insured _____ SS# & DOB of Primary Insured _____

Employer of Primary Insured _____

Has any member of your family been treated in our office? Yes No Name _____

Whom may we thank for referring you to our office? _____

Call in case of emergency _____ Relationship _____ Phone _____

MEDICAL HEALTH

Name and address of Physician _____

Physician's Phone _____ Last complete physical _____

Please check those conditions that now or have ever pertained to you:

YES NO

- ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN?
- HEART MURMUR OR CONGENITAL HEART DEFECT
- HEART SURGERY OR HEART DISEASE
- MITRAL VALVE PROLAPSE
- HEART PACEMAKER
- ABNORMAL BLOOD PRESSURE HIGH / LOW
- BLEEDING PROBLEMS
- DIABETES
- KIDNEY DISEASE
- JAUNDICE OR LIVER DISEASE
- CANCER
- HEPATITIS
- HAVE YOU EVER TESTED H.I.V. POSITIVE?
- JOINT REPLACEMENT
- CONVULSIONS OR EPILEPSY
- DIZZINESS OR FAINTING SPELLS
- STROKE
- LUNG PROBLEMS OR TUBERCULOSIS
- THYROID DISEASE
- Drug Addiction

YES NO

- GLAUCOMA
- ULCERS
- ARTHRITIS
- BLOOD DISEASE IE ANEMIA
- SINUS TROUBLE
- ARE YOU PREGNANT?
- HAVE YOU EVER TAKEN ANY DRUGS FOR OSTEOPOROSIS SUCH AS FOSOMAX, BONIVA OR I.V. ZOMETIA OR AREDIA?

ARE YOU ALLERGIC OR SENSITIVE TO:

- PENICILLIN
 - ASPIRIN
 - CODEINE
 - DEMEROL
 - LATEX RUBBER
 - LOCAL ANAESTHETICS LIKE
 - NOVACAINE
- ALLERGIES NOT LISTED**
- _____
 - _____

List all prescription medications you are currently taking:

Medication

Purpose

