PATIENT INFORMATION

Name _____
(PLEASE PRINT) Last First

Home Address _____ Apt. No. _____ Phone ( ) _____ Cell Phone ( ) _____

City _____ State _____ Zip _____

Soc. Sec. No. _____ Date of Birth _____ Age _____ Sex ◯M ◯F

Employer _____ Occupation _____

Business Address _____ City _____ Zip _____ Phone ( ) _____

Name of Spouse _____ Birthday _____ Soc. Sec. No. _____

Employer _____ Occupation _____

Patient's Dentist _____ Person who referred you (if not patient's dentist) _____

Patient's Physician _____ Phone ( ) _____ Date of last exam _____

IF YOU HAVE DENTAL INSURANCE PLEASE COMPLETE THE FOLLOWING (IF TWO POLICIES, COMPLETE BOTH PORTIONS)
An insurance policy is a contract between the patient and/or the employer and the insurance company, not between the doctor and the insurance company. We are pleased to complete all papers necessary for claims, However, please be aware that responsibility for payment remains with the patient.

Insured Person _____ Insured Person _____
Name of Insurance Co. _____ Name of Insurance Co. _____
Group No. _____ Soc. Sec. No. _____ Group No. _____ Soc. Sec. _____

MEDICAL HISTORY

CIRCLE ONE

1. Has there been any change in your general health within the last year? . . . . . Yes ◯ No ◯
   If yes, explain _____
2. Have you been a patient in any hospital during the past two years? . . . . . Yes ◯ No ◯
   If yes, explain _____
3. Have you been under the care of a medical doctor during the past two years? . . . . . Yes ◯ No ◯
   If yes, nature of treatment _____
4. Have you ever used Bisphosphonate medication to treat osteoporosis or metastatic cancer? . . . . . Yes ◯ No ◯
   If so, circle which type: Oral = Fosamax, Actonel, Boniva. IV = Aredia, Zometa
5. Circle any of the following which you have had or have at present:

Latex Allergy ... Y N	Kidney trouble ... Y N	Chemotherapy ... Y N	Cold Sores ... Y N
Heart Failure ... Y N	Ulcers ... Y N	Arthritis ... Y N	Bleeding Problems ... Y N
Heart Disease or Attack ... Y N	Emphysema ... Y N	Cortisone Medication ... Y N	Epilepsy or Seizures ... Y N
Angina Pectoris ... Y N	Shortness of Breath ... Y N	Glaucoma ... Y N	Psychiatric Treatment ... Y N
High Blood Pressure ... Y N	Tuberculosis (TB) ... Y N	Pain in Jaw Joints ... Y N	Drug Allergies ☐
Heart Murmur ... Y N	Asthma ... Y N	HIV Positive ... Y N	(check box for yes):
Rheumatic Fever ... Y N	Hay Fever ... Y N	AIDS ... Y N	_____
Artificial Heart Valve ... Y N	Sinus trouble ... Y N	Hepatitis A (infectious) ... Y N	_____
Heart Pacemaker ... Y N	Allergies or Hives ... Y N	Hepatitis B (serum) ... Y N	_____
Heart Surgery ... Y N	Diabetes I or II ... Y N	Hepatitis C ... Y N	_____
Artificial Joint ... Y N	Thyroid Disease ... Y N	Liver Disease ... Y N	_____
Anemia ... Y N	Cancer or Tumor ... Y N	Blood Transfusion ... Y N	_____
Stroke ... Y N	Radiation Treatment ... Y N	Drug / Alcohol Addiction ... Y N	_____

6. Do you have any disease, condition, or problem not listed above? . . . . . ◯ ◯
   If yes, explain _____
7. Please list all current medications

   _____ _____ _____ _____
   _____ _____ _____ _____

8. Are you or could you be pregnant or nursing? . . . . . ◯ Yes ◯ No

To the best of my knowledge, all of the above answers are correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment.

Signature of patient, parent, or guardian _____ Date _____

Updated _____ Date _____ Doctor's Signature _____