PATIENT INFORMATION

Dr./Mr./Mrs./Miss/Ms.____ Date_______________
Last First Middle Birth date

Address____
Number Street City State Zip Code Area Code Telephone

If less than one year, previous address____

Social Security # ___________________________ E-mail Address____

Employer ____ _________________________
Name Business Address Present Position

____ _________________________
City State Zip Code Area Code Telephone Additional Telephone Number

Name of Spouse_____________________________ Referred By____

Person responsible for payment of this account:____
If different from patient name above, please provide the following information:

Address____
Number Street City State Zip Code Area Code Telephone

Social Security # __________________________ Relationship of patient to policy holder____________________________

Name of your dental insurance company _____________________________ Group #___________ Policy #_______________

Name of your spouse's dental insurance company ________________________ Group #___________ Policy #_______________

Emergency Contact ____
Name Relationship Area Code Telephone

Physician____ Specialty____

Please check if you have or have had any of the following:

___ High Blood Pressure
___ Low Blood Pressure
___ Circulatory Problems
___ Radiation Treatment
___ AIDS
___ HIV Positive
___ Alcoholism
___ Anemia
___ Angina Pectoris
___ Ankles that swell
___ Anorexia/Bulimia
___ Arthritis
___ Artificial Heart Valve
___ Artificial Joints (hip, knee)
___ Asthma/Respiratory Disease
___ Blood Transfusion
___ Bruise Easily
___ Chemotherapy
___ Diabetes
___ Drug Addiction
___ Emphysema
___ Epilepsy or Seizures
___ Fainting or Dizziness
___ Glaucoma
___ Hearing Problems
___ Hay Fever
___ Heart Disease or Attack
___ Heart Failure
___ Heart Murmur
___ Heart Pacemaker
___ Hemophilia
___ Excessive Bleeding
___ Hepatitis A (infection)
___ Hepatitis B (serum)
___ Herpes or Fever Blisters
___ Kidney Problems/Disease
___ Liver Disease
___ Lupus
___ Malignancies
___ Measles
___ Mumps
___ MVP
___ Psychiatric Care/Mental Illness
___ Rheumatic Fever
___ Scarlet Fever
___ Sickle Cell Disease
___ Sinus Trouble
___ Stroke
___ Thyroid Disease
___ Typhoid Fever
___ Tuberculosis
___ Ulcers
___ Venereal Disease
___ Reaction to Local Anesthesia
___ Surgery (Minor or Major)
Types ________________
Dates ________________
___ Allergies to Medicine/Drugs
List: ________________

Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment. If you checked any of the above, please describe in full detail.

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Please list any medications you are taking: Medication____________________________ For___________________________
Medication____________________________ For___________________________
Medication____________________________ For___________________________

Have you ever taken bisphosphonates like Actonel, Fosamax, Aredia or Zometa? YES NO

Do you drink alcoholic beverages? YES NO _____drinks per day

Tobacco?___________________ packs per day

What kind? ____________________________

FOR WOMEN:

Are you pregnant: YES NO Due date_________

Do you have a history of miscarriages? YES NO