PATIENT INFORMATION

Patient Name ____ Phone ______________________
(Last) (First) (Middle Initial)
Address ____Alt. Phone__________________

City __________________________ State_____ Zip Code __________ E-mail ________________________

Male ___ Female ___ Age_____ Birth date ____________ Social Security # ________________________

___ Married ___Widowed ___Single ___ Separated ___ Divorced ___ Partnered ___ Minor

Person responsible for account _____________________________________ Same address? Yes____ No____

If No, please provide Address ___________________________________Phone: _______________________

Patient Employer/ School ____________________________________ Occupation _______________________

Spouses Name _____________________________ Phone_____________________ Birth date _____________

Whom may we thank for referring you? ____

In case of Emergency who do we notify? _________________________________ Phone __________________

***Primary Insurance**

Subscriber ____ Relation to Patient ______________

Address ____ Phone ______________ SS# __________________
(If different than Patient)
City _____________________________ State _____ Zip _______________ Birth date _________________

Insurance Co. __________________________________ Group # ____________ ID # ___________________

Address ___________________________________ Phone _______________ Employer_________________

***Secondary Insurance**

Subscriber ____ Relation to Patient _________________________

Address _______________________________________ Phone __________________ SS# _________________
(If different than Patient)
City __________________________ State _____ Zip ____________ Birth date ___________________________

Insurance Co. _________________________________ Group # ____________ ID # ______________________

Address ___________________________________ Phone ________________ Employer_________________

*** Authorization for us to bill Insurance(s)** ____________________________________ **Date:** _______________

Dental History

Reason for today's visit _____________________________________ Former Dentist ___________________________

Address _______________________________________ Phone __________________ Date of last visit _____________

Bad Breath ___ Bleeding Gums ___ Clicking or popping jaw ___ Grinding teeth ___ Periodontal treatment ___

Loose teeth ___ Broken filling ___ Food collection between teeth ___ Sensitivity to cold ___ Sensitivity to hot ___

Sensitivity when biting ___ Sores or growths in your mouth ___ How often do you brush? ________ Floss? ______

PATIENT INFORMATION

Medical History

Physicians Name: ____ Date of Last Visit ____________________

Have you ever used bisphosophonate? Common names are Fosomax, Actonel, Atelvia, Didronel, Boniva (Circle which if yes)

Have you ever taken any of the group of drugs collectively referred to as "Fen-phen"? These include combinations of Lonimin, Adipex, Fastin (brand names of Phentermine), Pondimin (Fenfluramine) and Redux (dexfenfluramine). (Circle which if Yes)

Have you had any serious illnesses or operations? If so, describe ____________________________________

Do you have Artificial Joints? If so which? ___________________________ Date of placement __________

Do you take a Pre med antibiotic? ___ Yes ___ No If yes, what is it? _________________________________

(Women) Are you pregnant ______ Nursing _______ Taking Birth control _______

***Please List any medications as it is important information in your treatment:** ____

____

***Allergies :** Aspirin ___ Barbiturates ___Codeine ___ Iodine ___ Latex ___ Acrylic ___ Local Anesthetics ___

Penicillin ___Sulfa ___ Other allergies ____

***Check if you have had any of the following:**

Aids/HIV ___Yes ___ No

Anemia ___ Yes ___ No

Arthritis, Rheumatism ___ Yes ___No

Artificial Heart Valve ___ Yes ___No

Asthma ___ Yes ___No

Back Problems ___ Yes ___ No

Bleeding abnormally with Extractions or surgery ___ Yes ___ No

Blood Disease ___ Yes ___ No

Cancer ___ Yes ___ No

Chemical Dependency ___ Yes ___ No

Chemotherapy ___ Yes ___ No

Circulatory Problems ___Yes ___No

Congenital Heart Lesions ___Yes ___ No

Cortisone Treatments ___ Yes ___No

Dementia ___ Yes ___ No

Diabetes ___ Yes ___ No

Epilepsy ___ Yes ___ No

Emphysema ___ Yes ___ No

Fainting or Dizziness Spells ___ Yes ___ No

Glaucoma ___ Yes ___No

Headaches ___ Yes ___ No

Heart Murmur ___ Yes ___ No

Heart Problems ___ Yes ___No

Hepatitis Type ____ ___ Yes ___ No

Herpes ___ Yes ___ No

High Blood Pressure ___ Yes ___ No

High Cholesterol ___ Yes ___ No

Jaundice ___ Yes ___ No

Jaw Pain ___ Yes ___ No

Kidney Disease ___ Yes ___ No

Liver Disease ___ Yes ___ No

Low Blood Pressure ___ Yes ___ No

Mitral Valve Prolapse ___ Yes ___ No

Nervous problems ___ Yes ___ No

Pacemaker ___ Yes ___ No

Persistent Cough ___ Yes ___ No

Psychiatric Care ___ Yes ___ No

Radiation Treatment ___ Yes ___ No

Respiratory Disease ___ Yes ___ No

Scarlet Fever ___ Yes ___ No

Sinus Trouble ___ Yes ___ No

Special Diet ___ Yes ___ No

Stroke ___ Yes ___ No

Swollen Limbs or Glands ___ Yes ___ No

Thyroid Problems ___ Yes ___ No

Tonsillitis ___ Yes ___ No

Tuberculousis ___ Yes ___ No

Tumor or Growth ___ Yes ___ No

Ulcer ___ Yes ___ No

Venereal Disease ___ Yes ___ No