

**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**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

