Whom may we thank for referring you?____

PATIENT INFORMATION

Name: ________________________________ **DOB:**__________ **SS#:**________________
Email:______________________________ **DL#:**______________ **State:**_____ **Male or Female**
Address:____
City: ____ **State:**_____ **Zip:**____________
Single Married Divorced Widowed Separated Other
Cell#:____________________ **Hm#:**____________________ **Wk#:**____________________
Emergency Contact Name:_____________________ **Ph#1:**_____________ **Ph#2:**_____________

INSURANCE SUBSCRIBER INFORMATION:

(Please Give Drivers License or State Issued ID And Dental Insurance Card To Receptionist)
Subscriber Name:_________________________ **DOB:**____________ **ID#:**________________
Insurance Carrier Address:____
City: ____ **State:**_____ **Zip:**____________
Insurance Co.:________________________ **Group#:**_______________ **Ph#:**______________
Employer:___________________________ **Ph#:**_______________ **Date you started job:**_______

MEDICAL HISTORY

Physicians Name:___________________________ **Ph#:**______________ **Date of last visit:**_______
Are you currently under the care of a Physician or Specialist? Yes No
Your current physical health is? Good Fair Poor
Are you currently taking any Prescriptions/Over the counter drugs or supplements? Yes No

If yes, please list:____
____

Have you ever been told you need to pre-medicate prior to dental or other treatment? Yes No
Are you currently pregnant? Yes No **Week #:**________ **Are you nursing?** Yes No
Are you currently taking or have you ever taken any medication for osteoporosis? Yes No
If yes, what is the medication? ________________________ **Examples include:**
Boniva, Fosamax, Actonel, Forteo, Alendronate, Prolia (Denosumab) injection, Xgeva, Zometa, Reclast intravenous, Atelvia, Duavee, Teriparatide, Risendronate, Raloxifene (Evista)

Have you ever had any of the following diseases or medical issues? (Circle all that apply)

Abnormal Bleeding	**Alcohol/Drug Abuse**	**Anemia**	**Arthritis**	**Asthma**	**Stroke**
Artificial Joints/Valve	**Blood Transfusion**	**Cancer**	**Diabetes**	**Emphysema**	**Difficulty Breathing**
Epilepsy	**Glaucoma**	**Hay Fever**	**HIV/AIDS**	**Shingles**	**Fainting**
Frequent Headaches	**Heart Attack**	**Hemophilia**	**Hepatitis**	**Seizures**	**Heart Murmur**
Heart Surgery	**Pacemaker**	**Ulcers**	**Liver Disease**	**Tuberculosis**	**Kidney Disease**
Radiation Treatment	**Rheumatic Fever**	**Sickle Cell**	**Psychiatric**	**Sinus**	**High Blood Pressure**
Low Blood pressure	**Venereal Disease**	**MVP**	**Congenital Heart Defect**		**Thyroid Problems**

Other:____

Are you allergic to any of the following? (Circle all that apply)

Aspirin	**Erythromycin**	**Metals**	**Codeine**	**Ibuprofen**	**Penicillin**
Tetracycline	**Latex**	**Dental Anesthetics**		**Other:**________________	

"I have answered all the above truthfully and to the best of my knowledge."

______________________________ ________________________ ________________
Patient/Guardian/Guarantor Signature **Dr. Signature** **Date**