

Patient Information:

Name _____ DOB _____ SS# _____
 Address _____
 City _____ State _____ Zip _____
 Phone Numbers:
 Home _____ Work _____ Cell _____
 E-mail _____
 Employer _____ Marital Status _____ Spouse _____
 Whom may we thank for referring you to our office _____
 Do any relatives come to our office? _____ If so, who? _____

Insurance Information:

Insurance Company Name _____
 Insured's Name _____ SS# _____
 Insured's Date of Birth _____ Employer _____
 Group# _____ ID# _____
 Insurance Co. Phone # _____

Medical Health History

Name of Physician _____ Phone # _____ Last Visit _____

Have you had or ever had any of the following? (list dates)

Abnormal Bleeding _____	High Blood Pressure _____
Alcohol/ Drug Abuse _____	HIV/AIDS _____
Anemia _____	Joint Replacement _____
Arthritis _____	Kidney Problems _____
Asthma _____	Latex Allergy _____
Cancer _____	Liver Problems _____
Diabetes _____	Low Blood Pressure _____
Difficulty Breathing _____	Pace Maker _____
Emphysema _____	Rheumatic Fever _____
Epilepsy/Seizures _____	Shingles _____
Fainting Spells _____	Sickle Cell Disease _____
Frequent Headaches _____	Sinus Problems _____
Glaucoma _____	Stroke _____
Hay Fever _____	Thyroid Problems _____
Heart Attack _____	Tuberculosis _____
Heart Murmur _____	Ulcers _____
Heart Surgery _____	Venereal Disease _____
Hemophilia _____	
Hepatitis _____ A _____ B _____ C _____	
Herpes/ Fever Blisters _____	

Other _____

Do you use tobacco? _____ Women are you pregnant? Yes or No Due Date _____

Are you currently taking blood thinners? Yes or No Name of Medication _____

Are you taking now or have ever taken Osteoporosis Medication? Yes or No

Fosamax / Zomate / Aredia / Other _____ When & how long ago? _____

Are you allergic to any of the following: Aspirin _____ Penicillin _____ Codeine _____ Acrylic _____ Metals _____

Anesthetic _____ Latex _____ Other _____

Please list any medications you are currently taking _____

List any medications you are allergic to _____

Have you been hospitalized within the last 2 years? _____ If so, for what _____

Have you been told to pre medicate before your dental appointments? _____

If yes, for what _____

Signature _____ Date _____