

PATIENT INFORMATION

(Please print)

Name _____ Date of birth ____/____/____
Last First M.I. mo. day yr.

Married (name of spouse) _____ Single Widowed Divorced Separated

Mailing Address _____ City/State _____

Zip Code _____ Home Phone # _(____)_____ Bus. Phone # _(____)_____

Occupation _____ Employer _____

Person responsible for account _____
(Include address if different from yours)

Name of referring dentist _____ Office Phone # _(____)_____

INSURANCE INFORMATION OF GUARANTOR

Name of Guarantor _____ Date of birth ____/____/____
(if different from patient name) mo. day yr.

Insurance company name _____ Guarantor's Soc. Sec. # _____ - _____ - _____

Insurance company address _____ Group / Policy # _____

HEALTH HISTORY

Are you under the care of a physician now? Yes No

Name of physician _____ Phone # _(____)_____

Condition(s) being treated _____

Please list medications you are taking and the dosage _____

Are you taking or have you taken bisphosphonate medicatons, (Actonel, Fosmax, or Zometa) Yes No

Have you ever had, or do you presently have (check appropriate boxes)

- | | | |
|---|---|---|
| <input type="checkbox"/> Abnormal Heart Condition or Murmur | <input type="checkbox"/> Asthma / Emphysema | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Abnormal Blood Pressure | <input type="checkbox"/> Blood / Bleeding Disorders | <input type="checkbox"/> Psychiatric / Psychological Care |
| <input type="checkbox"/> AIDS / Tested HIV Positive | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Radiation or Chemotherapy |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Hepatitis / Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Pacemaker or Artificial Heart Valves | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Surgery of the mouth, face, head or neck |

Please list known allergies (i.e., Penicillin, Latex) and any other information you or your doctor consider important.

Women: Are you: pregnant? Yes ___ months No ♦ Nursing? Yes No ♦ Taking birth control pills? Yes No

To the best of my knowledge the above information is correct and up to date.

Signature _____ Date _____