

Patient Information... Date _____

Mr. Mrs. Ms. Dr. First Name _____ M.I. ____ Last Name _____ Nickname _____

Mr. Mrs. Ms. Dr. First Name _____ M.I. ____ Last Name _____ Nickname _____

Sex: Male Female Birth Date _____ Age _____ Social Security Number _____

Sex: Male Female Birth Date _____ Age _____ Social Security Number _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Home Tel. (____) _____ Cell (____) _____ E-mail _____

Home Tel. (____) _____ Cell (____) _____ E-mail _____

Did you find our practice online? Yes No Referred By _____

Did you find our practice online? Yes No Referred By _____

Have you ever been a patient of our practice? Yes No Has a family member ever been a patient of our practice? Yes No

Have you ever been a patient of our practice? Yes No Has a family member ever been a patient of our practice? Yes No

Dentist _____ Medical Doctor _____

Dentist _____ Medical Doctor _____

Preferred Pharmacy _____ Tel. (____) _____

Preferred Pharmacy _____ Tel. (____) _____

Nearest relative not living with you _____ Tel. () _____

Nearest relative not living with you _____ Tel. () _____

Employer _____ Tel. (____) _____

Employer _____ Tel. (____) _____

In case of emergency, please contact _____ Tel. (____) _____ Relation _____

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Who Will Be Responsible For Your Account...

Self (if so, skip this section) Spouse Father Mother Other _____

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Name	S.S.#	Birth Date	Tel. ()
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Name	S.S.#	Birth Date	Tel. ()
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Street _____ Apt. _____ City _____ State _____ Zip _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Medical History...

Have you every had any illness, operation, or been hospitalized in the past three years? Yes No

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Have you, or a family member, had any unusual or serious reactions to general anesthesia? Yes No

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Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

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Y	N	Y	N	Y	N
	Rheumatic heart disease		Asthma		History of drug use
	High blood pressure		Mental health problems		History of alcohol abuse
	Low blood pressure		Problems with immune system		Abnormal bleeding/ bleeding tendency
	Heart murmur		Delay in healing		Blood transfusion
	Chest pain/ Angina		Sinus problems		Blood disorder
	Heart attack(s)		Sleep apnea		Bruise easily
	Irregular heartbeat		Snoring		Eye disease/ Glaucoma
	Cardiac pacemaker/ defibrillator		COPD		Jaundice/ Liver disease
	Heart surgery		Tuberculosis		Hepatitis
	Prosthetic heart valves		Emphysema		Fainting spells
	Coronary stents		Do you smoke? How much in a day?__		Convulsions/ Epilepsy
	Trouble breathing		Do you chew tobacco?		Thyroid trouble
	Anemia		Stroke		Diabetes
	Low blood sugar		HIV		Swollen ankles
	Are you on dialysis		Arthritis/ Joint disease		Prosthetic implant
	Kidney trouble		Osteoporosis/ Osteopenia		Joint replacement
	Stomach ulcers		Osteonecrosis		Organ transplant
	GI trouble/ IBS/ Colitis		Tumor or growth		Cancer/ Radiation/ Chemotherapy

Medication and Allergies...

Medications: Are you now taking:

Y N			Y N		
		Nerve pill			Insulin
		Diet pill			Antidepressants
		Tranquilizers			Blood thinner (Coumadin, Aspirin)
		Muscle relaxers			Stimulant
		Pain killer (including aspirin)			Are you taking, or have you ever taken bone density meds such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, or Evista in the last 12 yrs?

Please list **all** medications that you are currently taking:

Allergies: Are you allergic to, or had a reaction to:

Y N			Y N		
		Penicillin			Aspirin
		Amoxicillin			Codeine or other narcotics
		Sulfa drugs			Latex
		Local anesthetic (numbing medication)			Soy
		Sodium pentothal/ Valium/ other tranquilizers.			Sulfites (preservatives, wine, cheese)

Please list any other medication or antibiotic you are **allergic** to:

Medication/ Antibiotic Name	Reaction

Please list any allergies other than drug allergies:

1-4 below for women only: (Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/ gynecologist for assistance regarding additional methods of birth control.)

1) Is there a possibility of pregnancy? Yes No

2) Expected date: _____

3) Are you nursing? Yes No

4) Are you taking birth control? Yes No

I certify that I have read, and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any member of his staff, responsible for any errors or omissions that I have made in completion of this form.

X_____ Date _____

Fees & Payments

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge of any procedure or surgery you may require will be given to you upon request. If you have any dental insurance, we will be glad to fill out the proper forms, but please complete the identifying information on this form. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorney fees, and court cost.

X_____ Date _____

This signature on file is my authorization for the release of information necessary to process the claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X_____ Date _____

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X_____ Date _____