Patient Information

Date of birth_____
First name_____ Last name_____
Address_____
Phone # Home_____ Business_____ Cell_____

Medical History

Have you had a serious illness, operation, or been hospitalized in the past? _____
If yes, what was the illness/or problem?_____
Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)?
Date _____ Any complications? _____
Are you taking Fosamax, Actonel, or Boniva, for osteoporosis?_____
Were you treated or are you presently being treated with intravenous bisphosphonates (such as Aredia or Zometa) for bone pain, hypercalcemia, Pagets, Multiple Myeloma, Metastatic cancer?
Date_____
Do you have history of:
-Artificial heart valve _____
-Previous infective endocarditis_____
-Damaged valves in a heart transplant_____
-Congenital heart disease_____
-Unrepaired, cyanotic CHD
-Repaired in last 6 months
-Repaired CHD with residual defects
Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of heart disease.

Y	N	Conditions
☐	☐	Allergies (seasonal)
☐	☐	Anemia
☐	☐	Angina
☐	☐	Arthritis
☐	☐	Artificial bones / joints
☐	☐	Asthma
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Congenital heart defect
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Eating disorder
☐	☐	Glaucoma
☐	☐	Heart attack
☐	☐	Heart problems/ surgery
☐	☐	Heart murmur
☐	☐	Hepatitis

Y	N	Conditions
☐	☐	High blood pressure
☐	☐	High Cholesterol
☐	☐	HIV/AIDS
☐	☐	Kidney Problems
☐	☐	Liver problems
☐	☐	Mental disorders
☐	☐	Mitralvalve Prolapse
☐	☐	Pacemaker
☐	☐	Pregnant
☐	☐	Radiation therapy
☐	☐	Rheumatic fever
☐	☐	Respiratory problems
☐	☐	Sinus problems
☐	☐	Stroke
☐	☐	Tobacco habit
☐	☐	Thyroid problems
☐	☐	Tuberculosis

Y	N	Allergies
☐	☐	Anesthetic
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Food
☐	☐	Latex
☐	☐	Metal
☐	☐	Penicillin
☐	☐	Sulfa
☐	☐	Other

Are you taking any prescriptions or over the counter medications? If yes, please list all.

_____
_____
_____
_____

Signature _____ Date _____

The above information is accurate and complete to the best of my knowledge.

PATIENT INFORMATION FORM

Name (Last, First, Middle) : _____ Title : _____

Preferred Name : _____ Sex _____

SS NO : _____-_____-_____ DOB : _____-_____-_____ Age _____ Marital S /M /D /W

If under 18

Mother _____ DOB: _____-_____-_____ SS No. _____-_____-_____

Father _____ DOB: _____-_____-_____ SS No _____-_____-_____

Favorite Toy _____ Favorite Sport _____ Hobby_____

Home Address : _____

City Zip

Home Phone: (____)_____ Work Phone (____)_____ Cell (____)_____

Occupation : _____ Employer : _____

E-Mail _____ Drivers License No: _____

Referred by _____

Emergency Contact : _____ Phone No : _____

Name of Physician: _____ Pharmacy :_____

Telephone No: _____

PRIMARY DENTAL INSURANCE

Subscriber Name: _____ Relation to Patient : _____

SS No: _____-_____-_____ DOB _____-_____-_____

Name of Insurance _____

Group Name : _____ Group No: _____

Insurance Telephone No: _____ E-Mail Address _____

Insurance Billing Address : _____

Subscriber's Employer: _____ Phone: _____

**We will bill your insurance as a benefit to you. Co-payments and percentages will be collected at the time of service. Please remember that having insurance does not guarantee full coverage of all procedures. You are still responsible for your account. Accounts over 90 days will be subject to a finance charge. Accounts extending beyond 120 days will be sent to collections. We are here to make you feel comfortable and hopefully all your questions have been answered to the best of our ability.

Signature of patient or guardian_____Date_____