## 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)

| | | |
|---|---|---|
| ☐ Abnormal Heart Condition or Murmur | ☐ Asthma / Emphysema | ☐ Kidney Disease |
| ☐ Abnormal Blood Pressure | ☐ Blood / Bleeding Disorders | ☐ Psychiatric / Psychological Care |
| ☐ AIDS / Tested HIV Positive | ☐ Diabetes | ☐ Rheumatic Fever |
| ☐ Allergies or Hives | ☐ Epilepsy or Seizures | ☐ Radiation or Chemotherapy |
| ☐ Arthritis | ☐ Hay fever | ☐ Sinus trouble |
| ☐ Artificial Joints | ☐ Hepatitis / Liver Disease | ☐ Tuberculosis |
| ☐ Pacemaker or Artificial Heart Valves | ☐ Venereal Disease | ☐ 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** ________________________