PATIENT INFORMATION

Please complete and print clearly

Patient's name_____
Last First Middle

Mailing address_____
Street City State Zip

Home phone ( ) _____ Cell phone ( )_____

E-mail address_____ **Marital status**_____

Date of Birth_____ **Age** _____ **SS#** _____

Employer_____ **Employer phone ( )**_____

Name of Spouse (if married)_____

Name of Parent (if under 18 or single)_____

Employer of Spouse or Parent_____ **Employer Phone ( )**_____

In case of Emergency, call:

(1)_____ **Relationship**_____ **Phone ( )**_____

(2)_____ **Relationship**_____ **Phone ( )**_____

Person financially responsible_____ **Phone ( )**_____

Address of responsible party_____

Referred by _____

Reason for visit _____

(Please Complete Back Side of This Form)

MEDICAL HISTORY

*Please complete all sections, use **"NONE"** or **"NA"** where applicable.*

1. Are you allergic to any medications or have any allergiesto soy, eggs, or peanuts? (please list)_____
   _____
2. Are you currently taking any medications? (please list) _____
   _____
3. Please list all hospitalizations and previous surgeries. _____
   _____
4. Are you currently under the care of a physician? If so, who and why?:_
   _____
5. Are you taking or have you ever taken a Bisphosphonate drug such as Fosamax, Boniva, Actonel, Zometa, Aredia, Prolia, Reclast, Didronel, Skelid, or Xgeva to strengthen bones? YES NO
6. Have you or any family member had trouble with general anesthesia? YES NO
7. Do you have TMJ problems: popping, clicking, pain or locking of jaw joint? YES NO
8. Are you taking, or have you taken steroids, cortisone or prednisone in the past 12 months? YES NO
9. Do you have a chronic viral infection? YES NO
10. Do you use any tobacco products? YES NO
11. Are you taking or have you used illegal or street drugs within the past 12 months? YES NO
12. Have you had bone or joint replacements? YES NO

Have you ever had or do you have: (circle YES or NO for each)

Fainting Spells	YES	NO	Atrial Fibrillation	YES	NO
Seizures or Epilepsy	YES	NO	Heart Murmur	YES	NO
Prolonged Bleeding	YES	NO	Heart Valve Replacement	YES	NO
Organ Transplant	YES	NO	Heart Valve Problem	YES	NO
Glaucoma	YES	NO	Heart Attack	YES	NO
Recent Hoarseness	YES	NO	Heart Disease	YES	NO
Difficulty Swallowing	YES	NO	Congestive Heart Faliure	YES	NO
Shortness of Breath	YES	NO	Chest Pain or Angina	YES	NO
Morning Cough	YES	NO	Stroke	YES	NO
Sinus Trouble	YES	NO	Diabetes	YES	NO
Asthma or Lung Disease	YES	NO	Hepatitis/Liver Disease	YES	NO
Anemia/Leukemia	YES	NO	Venereal Disease	YES	NO
Porphyria	YES	NO	Tuberculosis (TB)	YES	NO
Blood Disorders	YES	NO	Stomach Ulcers	YES	NO
Sickle Cell Anemia	YES	NO	Cancer	YES	NO
Kidney Problems	YES	NO	Radiation Treatment	YES	NO
High Blood Pressure	YES	NO	Reaction to Anesthesia	YES	NO
			Thyroid Problem	YES	NO

FEMALES: Are you pregnant or possibly pregnant? YES NO If yes, how many weeks?_____

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

***SIGNATURE:_____ DATE: _____**

*Parent or Guardian must sign if patient is under 18.