Patient Information

Patient Name: ______________________________ Date: ________
Last, First MI (Preferred Name)

Gender: __________ Family Status: __________

Social Security #: ______________ Drivers License______________ Birth Date: __________

Phone (Home): ____________ (Work): ____________ (Cell): ______ Email: __________

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: ______________________________
Street Apartment #

____
City State Zip Code

Health Information

Date of Last Dental Visit: ______________ Reason for this visit: ______________

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies ________ ________
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints ____
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis: type ___
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:________
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:
☐ ____________

BLOOD THINNERS
☐ ____________

Bisphosphonate use:

Have you ever had: ☐ Bone cancer ☐ Bone disease ☐ Osteoporosis

Have you ever been on Bone strengthen medicine? ☐ **Yes** ☐ **No** **If yes, please check those that apply:**
☐ Zomata ☐ Zoledronate ☐ Aredia ☐ Pamidronate ☐ Fosamax ☐.Alendronate ☐ Actonel ☐ Risedronate ☐Didronel ☐ Etidronate ☐ Boniva ☐Ibandronate ☐Skelid ☐ Tiludronate

Have you ever been diagnosed with Osteochemonecrosis? (OCN) ☐ **Yes** ☐ **No**

- Are you on any medication at this time? ☐ Yes ☐ No
  If yes, please list: ______________________________
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Name of Physician: ______________________ Phone: ____________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ______________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

______________________________ Date: ____________
Signature of patient, parent or guardian

Turn over