PATIENT INFORMATION

Last Name: _____ First Name: _____ DOB: _____ Sex: M / F

SS Number: _____ Marital Status: _____

Address: _____ City: _____ State: ____ Zip: _____

Home (____) _____ Cell (____) _____ Email: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Reason for visit: _____

How did you hear about us: _____

***Please bring your Driver's License and Insurance Cards to your appointment.**

HEALTH HISTORY

1.Are you currently under the care of a physician? Yes / No Date of Last Visit _____

Physician's Name _____ Office Phone (_____) _____-_____

2. Have you had any recent hospitalizations, surgeries, or continuance of medical care? If Yes, please explain

_____

3. List all medications you take on a regular basis (Including over the counter and herbal supplements)

_____

_____

4. Have you had an adverse reaction, or are you ALLERGIC to any medications? If Yes, please explain

_____

5. Have you ever been treated with BISPHOSPHONATE drugs such as: Fosamax, Actonel, Boniva, IV Aredia, IV Reclast or IV Zometa? Yes / No

6. Do you have any JOINT REPLACEMENT(s)? Yes / No If Yes, where: _____

7. Have you ever had CHEMOTHERAPY? Yes / No If Yes, for what reason: _____

8. Have you ever had RADIATION to the head or neck area, specifically the jaws? If Yes, please explain

_____

9. Do you smoke? Yes / No Do you drink alcohol? Yes / No

10. Is there a family history or history of problems with ANESTHESIA? Yes / No

Have you had PREVIOUSLY or do you CURRENTLY have any of the following: (Please Circle):

High blood pressure	Yes / No	Low Blood pressure	Yes / No
Stroke	Yes / No	Heart Attack	Yes / No
Heart murmur	Yes / No	Heart surgery	Yes / No
Irregular heart beat	Yes / No	Pacemaker	Yes / No
Fainting	Yes / No	Chest pain	Yes / No
Dizziness	Yes / No	Shortness of breath	Yes / No
Asthma	Yes / No	Emphysema/COPD	Yes / No
Pneumonia	Yes / No	Bronchitis/Chronic cough	Yes / No
Sinus problems	Yes / No	Hay fever/Allergies	Yes / No
Sleep apnea	Yes / No	Bleeding disorders	Yes / No
Liver disorders	Yes / No	Bruise easily	Yes / No
Hepatitis/Jaundice	Yes / No	Kidney disorders	Yes / No
Dialysis	Yes / No	Thyroid disorders	Yes / No
Eye diseases	Yes / No	Diabetes	Yes / No
Epilepsy/Seizures	Yes / No	Osteoporosis	Yes / No
Stomach ulcers	Yes / No	Gastric reflux	Yes / No
Chronic fatigue	Yes / No	Night sweats	Yes / No
Immune disorders	Yes / No	Cancer	Yes / No
Anemia	Yes / No	Blood thinners	Yes / No
Contagious diseases	Yes / No	Tuberculosis	Yes / No
Arthritis	Yes / No	Leg/Ankle swelling	Yes / No
Anxiety	Yes / No	Mental health disorders	Yes / No

*Is there any other medical condition that you have had or currently have not listed above?

FEMALES ONLY: Please answer the following questions

Are you pregnant or trying to become pregnant? Yes / No

Are you currently nursing? Yes / No

Are you on any type of birth control? Yes / No

I certify that I understand the questions above and answered them truthfully. I will not hold my surgeon or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Patient or Guardian Signature and (Relation)	Date
Doctor Signature	Date