PATIENT INFORMATION

Patient Name: ____ Date: ___/__/_____

Soc. Sec. #:_____-____-_______ Birth date: ____/___/______ DL#:_______________________

Home Address: ____

City: ___________________________________ State: _________ Zip Code: _____________

Home Phone: (______)_________-____________ Cell Phone: (______)_______-______________

Email Address: ____

Emergency Contact Name: _______________________________ Phone:(_____)______________

• Have you ever had any allergic reactions to the following:

☐ Local Anesthetics ☐ Penicillin ☐ Other Antibiotics ☐ Sulfa Drugs ☐ Aspirin ☐ Latex/ ☐ Iodine
☐ Nitrous Oxide ☐ Barbiturates (sleeping pills) ☐ Codeine ☐ Tetracycline ☐ Erythromycin ☐ Epinephrine

• Have you ever taken any of the following:

☐ Actonel ☐ Aredia ☐ Boniva ☐ Fosamax ☐ Reclast ☐ Zometa ☐ Herbal Supplements

Please check all that apply:

☐ Aids	☐ HIV	☐ Headaches	☐ Chemical Dependency	☐ Kidney Disease
☐ Rheumatic Fever	☐ Anemia	☐ Chemotherapy	☐ Arthritis	☐ Heart Murmur
☐ Liver Disease	☐ Scarlet Fever	☐ Circulatory Problems	☐ Heart Problems	☐ Low Blood Pressure
☐ Shortness of Breath	☐ Artificial Heart Valves		☐ Sinus Trouble	☐ Herpes
☐ Hepatitis –type-	☐ Mitral Valve Prolapsed		☐ Artificial Joints	☐ Congenital Heart Disease
☐ Stroke	☐ Nervous Problems		☐ Asthma	☐ Cortisone Treatment
☐ High Blood Pressure	☐ Pins, Plates, Screws		☐ Swollen neck Gland	☐ Back Problems
☐ Diabetes	☐ Pacemaker	☐ Thyroid Problems	☐ Bleeding	☐ Epilepsy
☐ Hypoglycemic	☐ Psychiatric Care	☐ Tonsillitis	☐ Blood Disease	☐ Cancer
☐ Fainting or Dizziness	☐ Jaundice	☐ Radiation Treatment	☐ Tuberculosis	☐ Jaw Pain
☐ Ulcers	☐ Glaucoma	☐ Respiratory Disease	☐ Cardiovascular Disease	☐ High Cholesterol

Any Surgery in the past 3 years? Y or N If yes, Surgery Type & Date: ____________________________

Medications List:____

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Patient Signature _______________________________ Doctor Signature __________________________

Date __________________________