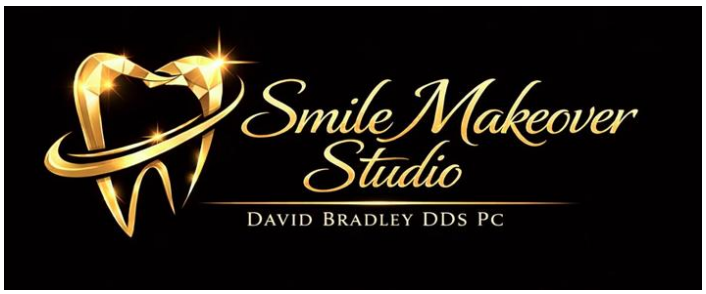
**Patient Information**




**Date:** _____

**SS#:** _____

**Patient Name:** _____

**Date of Birth:** _____

**Phone Number:** _____

**Address:** _____ **State:** _____ **Zip:** _____

**Email:** _____

**Sex:** M ☐ F ☐

☐Married ☐Widowed ☐Single

☐Separated ☐Divorced ☐Partner

**Reason for today's visit:** _____

**Current dental concerns:** _____

**Date of last dental visit:** _____

**Patent Employer:** _____

**Occupation:** _____

**How did you hear about us?** _____

**In case of emergency, contact:** _____

**Emergency contact phone number:** _____

**Bleeding gums?** ☐Yes ☐No

**Jaw Pain?** ☐Yes ☐No

**Broken teeth?** ☐Yes ☐No

**Dental/mouth pain?** ☐Yes ☐No

**Dental Insurance**

**Who is responsible for this account:** _____

**Relationship to patient:** _____

**Insurance Co.**_____

**Group #:** _____

**Is patient covered by additional insurance?** ☐Yes ☐No

**Subscriber Name:** _____

**Subscriber Date of Birth:** _____

**SS#:** _____

**Group # (secondary, if applicable):** _____

*Assignment and Release*

**I certify that I, and/or my dependent(s), have insurance coverage as listed above and assign directly to David Bradley DDS PC. All insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. David Bradley DDS PC may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.**

**Signature of patient, parent, guardian, or representative:** _____

**NEXT PAGE (OVER)**

## Health History

**Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, & Boniva;** ☐Yes ☐No

**Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine);**

☐Yes ☐No

**Place a mark on "yes" or "no" to indicate if you have/had any of the following;**

| | | | | | |
|---|---|---|---|---|---|
| AIDS/HIV | ☐Yes | ☐No | Epilepsy | ☐Yes | ☐No |
| Anemia | ☐Yes | ☐No | Fainting or dizziness | ☐Yes | ☐No |
| Arthritis, Rheumatism | ☐Yes | ☐No | Glaucoma | ☐Yes | ☐No |
| Artificial Heart Valves | ☐Yes | ☐No | Headaches | ☐Yes | ☐No |
| Artificial Joints | ☐Yes | ☐No | Heart Murmur | ☐Yes | ☐No |
| Asthma | ☐Yes | ☐No | Heart Problems | ☐Yes | ☐No |
| Back Problems | ☐Yes | ☐No | Hepatitis Type _____ | ☐Yes | ☐No |
| Bleeding abnormally | ☐Yes | ☐No | Herpes | ☐Yes | ☐No |
| Blood Disease | ☐Yes | ☐No | High Blood Pressure | ☐Yes | ☐No |
| Cancer | ☐Yes | ☐No | Jaundice | ☐Yes | ☐No |
| Chemical Dependency | ☐Yes | ☐No | Jaw Pain | ☐Yes | ☐No |
| Chemotherapy | ☐Yes | ☐No | Kidney Disease | ☐Yes | ☐No |
| Circulatory Problems | ☐Yes | ☐No | Liver Disease | ☐Yes | ☐No |
| Congenital Heart Lesions | ☐Yes | ☐No | Low Blood Pressure | ☐Yes | ☐No |
| Cortisone Treatments | ☐Yes | ☐No | Mitral Valve Prolapse | ☐Yes | ☐No |
| Cough, persistent or bloody | ☐Yes | ☐No | Nervous Problems | ☐Yes | ☐No |
| Diabetes | ☐Yes | ☐No | Pacemaker | ☐Yes | ☐No |
| Emphysema | ☐Yes | ☐No | Psychiatric Care | ☐Yes | ☐No |
| Do you wear contact lenses? | ☐Yes | ☐No | Radiation Treatment | ☐Yes | ☐No |
| Respiratory Disease | ☐Yes | ☐No | Rheumatic Fever | ☐Yes | ☐No |
| Scarlet Fever | ☐Yes | ☐No | Shortness of Breath | ☐Yes | ☐No |
| Sinus Trouble | ☐Yes | ☐No | Skin Rash | ☐Yes | ☐No |
| Special Diet | ☐Yes | ☐No | Stroke | ☐Yes | ☐No |
| Swollen Feet/Ankles | ☐Yes | ☐No | Swollen Neck Glands | ☐Yes | ☐No |
| Thyroid Problems | ☐Yes | ☐No | Tonsillitis | ☐Yes | ☐No |
| Tuberculosis | ☐Yes | ☐No | Tumor or growth; neck or head | ☐Yes | ☐No |
| Ulcer | ☐Yes | ☐No | Venereal Disease | ☐Yes | ☐No |
| Weight Loss, unexplained | ☐Yes | ☐No | | | |

**Women:** Are you pregnant? ☐Yes ☐No (if yes, due date: _____)
Taking birth control pills? ☐Yes ☐No

## Medications

**List any medications you are currently taking and the correlating diagnosis:**

_____

_____

_____

## Allergies

☐Aspirin ☐Local Anesthetic ☐Barbiturates (sleeping pills) ☐Penicillin ☐Codeine

☐Sulfa ☐Iodine ☐Latex ☐Other: _____

**Patient Signature:** _____ **Date:** _____