HEALTH HISTORY

Date of last medical exam: ________________ What was this exam for? _________________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: ____

Are you currently under a physician's care? No Yes If yes, nature of care: _____________________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
2. ____
3. ____

Please list any medications you are currently taking and dosages:

1. ____
2. ____
3. ____
4. ____

Do you take a Pre-medication prior to dental appointments? NO YES

If "YES", for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES

If so, when did the treatment begin? ______________________ When did the treatment end?_____________________________

Are you currently taking any blood thinners? NO YES Which Drug:____

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you allergic or have you had a reaction to:

a. Local anesthetics No Yes
b. Penicillin No Yes
c. Aspirin, Ibuprofen or Tylenol No Yes
d. Codeine, Valium or sedatives No Yes
e. Latex or Metals No Yes
f. Other (please specify)_________________________

For the following questions circle yes or no.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	High Blood Pressure	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Low Blood Pressure	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Thyroid Disease	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Recurrent Illnesses	No	Yes
Heart Stent? When placed?	No	Yes	Do you use tobacco?	No	Yes

Signature:____

Welcome to Deak Medical Dentistry

Please take a few moments to complete this form in its entirety. All information will be considered confidential, and will be released only as allowed through HIPAA regulations, and as considered necessary for treatment, payment, or other health care operations.

MUST FILL OUT ALL THE INFORMATION FULLY.

PATIENT INFORMATION

Date____________________

First Name ____________________________ Last Name ______________________________ MI_____________

Sex □ M □F Date of Birth__________ Age: ________ * Social Security number ______________________________
MUST HAVE SOCIAL SECURITY NUMBER TO SUBMIT TO DENTAL/MEDICAL INSURANCE

Address____

City_____________________________________ State _______________ ZIP ________________________

Home Phone ____________________________ Cell Phone _______________________________________

Email ___________________________________

Marital Status (check one) □Minor □Single □Married □Divorced □Widowed □Separated

Employer____ Work Phone____________________________________

Employer Address__________________________________ City_______________ State________ Zip___________

Emergency Contact_________________________________ Relationship________________ Phone______________

MUST BE UPDATED EACH YEAR WITH ALL INFORMATION

DENTAL INSURANCE INFORMATION

Insurance Holder's Name ____________________ Relationship to Insured □Self □Spouse □Child □Other

Insurance Holder's date of birth____________ Insurance Holder's social security number_________________

Insurance Company ____

**The proceeding information will be on your dental insurance card.*

Member ID______________________ Group #________________________ Employer_________________________

Insurance Company Address ____

Insurance Company phone number____

FEDERAL EMPLOYEE'S ONLY

MEDICAL INSURANCE INFORMATION

Insurance Holder's Name _______________________ Relationship to Insured □Self □Spouse □Child □Other

Insured's holder date of birth______________ Insurance Holder's social security_______________

Insurance company_____________________

**The proceeding information will be on your medical card*

Member ID______________________ Group #________________________ Employer_________________________

Insurance Company Address ____

Insurance Company phone number____

We need all correct information to submit to your dental/medical insurance. Incorrect information will be patient responsibility for financial and resubmission.

Assignment of benefits to physician: I authorize the release of medical or other information necessary to process health insurance claims on my behalf. I also request payment of benefits to Deak Medical Dentistry when assignment of benefits is accepted.

Consent to treat: I, the undersigned, authorize medical treatment for **myself** or my minor child, _______________________, as deemed necessary and provided by Dr. Deak and Deak Medical Dentistry

I have read and understand the privacy policy for the office of Deak Medical Dentistry_____________________________.

PATIENT PRINTED NAME: ____DATE________________

PATIENT OR PARENT/GUARDIAN SIGNATURE: ____

HEALTH HISTORY

Date of last medical exam: ________________ What was this exam for? __________________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: ____

Are you currently under a physician's care? No Yes If yes, nature of care: ______________________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
2. ____
3. ____

Please list any medications you are currently taking and dosages:

1. ____
2. ____
3. ____
4. ____

Do you take a Pre-medication prior to dental appointments? NO YES

If "YES", for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES

If so, when did the treatment begin? _______________________ When did the treatment end? ______________________________

Are you currently taking any blood thinners? NO YES Which Drug: ____

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you allergic or have you had a reaction to:

a. Local anesthetics No Yes
b. Penicillin No Yes
c. Aspirin, Ibuprofen or Tylenol No Yes
d. Codeine, Valium or sedatives No Yes
e. Latex or Metals No Yes
f. Other (please specify) __________________________

For the following questions circle yes or no.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	High Blood Pressure	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Low Blood Pressure	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Thyroid Disease	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Recurrent Illnesses	No	Yes
Heart Stent? When placed?	No	Yes	Do you use tobacco?	No	Yes

Signature: ____

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PATIENT INFORMATION

Date____________________

First Name ____________________________ Last Name ______________________________ MI _____________

Sex □ M □F Date of Birth__________ Age: ________ * Social Security number ______________________________

MUST HAVE SOCIAL SECURITY NUMBER TO SUBMIT TO DENTAL/MEDICAL INSURANCE

Address ____

City ____ State ________________ ZIP __________________________

Home Phone _____________________________ Cell Phone ____

Email ____________________________________

Marital Status (check one) □Minor □Single □Married □Divorced □Widowed □Separated

Employer ____ Work Phone ______________________________________

Employer Address ___________________________________ City ________________ State _________ Zip ___________

Emergency Contact __________________________________ Relationship _________________ Phone ______________

MUST BE UPDATED EACH YEAR WITH ALL INFORMATION

DENTAL INSURANCE INFORMATION

Insurance Holder's Name ____________________ Relationship to Insured □Self □Spouse □Child □Other

Insurance Holder's date of birth____________ Insurance Holder's social security number__________________

Insurance Company ____

**The proceeding information will be on your dental insurance card.*

Member ID______________________ Group #________________________ Employer___________________________

Insurance Company Address ____

Insurance Company phone number____

FEDERAL EMPLOYEE'S ONLY

MEDICAL INSURANCE INFORMATION

Insurance Holder's Name _______________________ Relationship to Insured □Self □Spouse □Child □Other

Insured's holder date of birth______________ Insurance Holder's social security________________

Insurance company_____________________

**The proceeding information will be on your medical card*

Member ID______________________ Group #________________________ Employer___________________________

Insurance Company Address ____

Insurance Company phone number____

We need all correct information to submit to your dental/medical insurance. Incorrect information will be patient responsibility for financial and resubmission.

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I have read and understand the privacy policy for the office of Deak Medical Dentistry_____________________________.

PATIENT PRINTED NAME: ____ DATE_________________

PATIENT OR PARENT/GUARDIAN SIGNATURE: ____

HEALTH HISTORY

Date of last medical exam: ________________ What was this exam for? ___________________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: ____

Are you currently under a physician's care? No Yes If yes, nature of care: _______________________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
2. ____
3. ____

Please list any medications you are currently taking and dosages:

1. ____
2. ____
3. ____
4. ____

Do you take a Pre-medication prior to dental appointments? NO YES

If "YES", for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES

If so, when did the treatment begin? _______________________ When did the treatment end?______________________________

Are you currently taking any blood thinners? NO YES Which Drug:____

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you allergic or have you had a reaction to:

a. Local anesthetics No Yes
b. Penicillin No Yes
c. Aspirin, Ibuprofen or Tylenol No Yes
d. Codeine, Valium or sedatives No Yes
e. Latex or Metals No Yes
f. Other (please specify)__________________________

For the following questions circle yes or no.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	High Blood Pressure	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Low Blood Pressure	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Thyroid Disease	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Recurrent Illnesses	No	Yes
Heart Stent? When placed?	No	Yes	Do you use tobacco?	No	Yes

Signature:____

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PATIENT INFORMATION

Date___________________

First Name ___________________________ Last Name _____________________________ MI _____________

Sex □ M □F Date of Birth__________ Age: ________ * **Social Security number** ____________________________

MUST HAVE SOCIAL SECURITY NUMBER TO SUBMIT TO DENTAL/MEDICAL INSURANCE

Address ____

City____ State_______________ ZIP_________________________

Home Phone ____________________________ Cell Phone _______________________________________

Email ___________________________________

Marital Status (check one) □Minor □Single □Married □Divorced □Widowed □Separated

Employer____ Work Phone_____________________________________

Employer Address__________________________________ City_______________ State_________ Zip___________

Emergency Contact_________________________________ Relationship________________ Phone______________

MUST BE UPDATED EACH YEAR WITH ALL INFORMATION

DENTAL INSURANCE INFORMATION

Insurance Holder's Name ___________________ Relationship to Insured □Self □Spouse □Child □Other

Insurance Holder's date of birth____________ Insurance Holder's social security number_________________

Insurance Company ____

**The proceeding information will be on your dental insurance card.*

Member ID_____________________ Group #_______________________ Employer_________________________

Insurance Company Address ____

Insurance Company phone number____

FEDERAL EMPLOYEE'S ONLY

MEDICAL INSURANCE INFORMATION

Insurance Holder's Name ______________________ Relationship to Insured □Self □Spouse □Child □Other

Insured's holder date of birth______________ Insurance Holder's social security_______________

Insurance company____________________

**The proceeding information will be on your medical card*

Member ID_____________________ Group #_______________________ Employer_________________________

Insurance Company Address ____

Insurance Company phone number____

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I have read and understand the privacy policy for the office of Deak Medical Dentistry___________________________.

PATIENT PRINTED NAME: ____ DATE_______________

PATIENT OR PARENT/GUARDIAN SIGNATURE: ____

HEALTH HISTORY

Date of last medical exam: ________________ What was this exam for? __________________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: ____

Are you currently under a physician's care? No Yes If yes, nature of care: ______________________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
2. ____
3. ____

Please list any medications you are currently taking and dosages:

1. ____
2. ____
3. ____
4. ____

Do you take a Pre-medication prior to dental appointments? NO YES

If "YES", for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES

If so, when did the treatment begin? _______________________ When did the treatment end?______________________________

Are you currently taking any blood thinners? NO YES Which Drug:____

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you allergic or have you had a reaction to:

a. Local anesthetics No Yes
b. Penicillin No Yes
c. Aspirin, Ibuprofen or Tylenol No Yes
d. Codeine, Valium or sedatives No Yes
e. Latex or Metals No Yes
f. Other (please specify)__________________________

For the following questions circle yes or no.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	High Blood Pressure	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Low Blood Pressure	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Thyroid Disease	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Recurrent Illnesses	No	Yes
Heart Stent? When placed?	No	Yes	Do you use tobacco?	No	Yes

Signature:____

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PATIENT INFORMATION **Date**____________________

First Name ___________________________ Last Name_____________________________ MI_____________

Sex □ M □F Date of Birth__________ Age: ________ * **Social Security number** ____________________________

MUST HAVE SOCIAL SECURITY NUMBER TO SUBMIT TO DENTAL/MEDICAL INSURANCE

Address____

City____ State_______________ ZIP_________________________

Home Phone ____________________________ Cell Phone_______________________________________

Email ___________________________________

Marital Status (check one) □Minor □Single □Married □Divorced □Widowed □Separated

Employer____ Work Phone_____________________________________

Employer Address__________________________________ City_______________ State________ Zip__________

Emergency Contact_________________________________ Relationship________________ Phone_____________

MUST BE UPDATED EACH YEAR WITH ALL INFORMATION

DENTAL INSURANCE INFORMATION

Insurance Holder's Name ____________________ Relationship to Insured □Self □Spouse □Child □Other

Insurance Holder's date of birth____________ Insurance Holder's social security number_________________

Insurance Company____

**The proceeding information will be on your dental insurance card.*

Member ID_____________________ Group #_______________________ Employer________________________

Insurance Company Address ____

Insurance Company phone number____

FEDERAL EMPLOYEE'S ONLY

MEDICAL INSURANCE INFORMATION

Insurance Holder's Name _______________________ Relationship to Insured □Self □Spouse □Child □Other

Insured's holder date of birth______________ Insurance Holder's social security_______________

Insurance company_____________________

**The proceeding information will be on your medical card*

Member ID_____________________ Group #_______________________ Employer________________________

Insurance Company Address ____

Insurance Company phone number____

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I have read and understand the privacy policy for the office of Deak Medical Dentistry____________________________.

PATIENT PRINTED NAME: ____DATE_______________

PATIENT OR PARENT/GUARDIAN SIGNATURE: ____

HEALTH HISTORY

Date of last medical exam: ________________ What was this exam for? __________________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: ____

Are you currently under a physician's care? No Yes If yes, nature of care: ______________________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
2. ____
3. ____

Please list any medications you are currently taking and dosages:

1. ____
2. ____
3. ____
4. ____

Do you take a Pre-medication prior to dental appointments? NO YES

If "YES", for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES

If so, when did the treatment begin? _______________________ When did the treatment end?______________________________

Are you currently taking any blood thinners? NO YES Which Drug:____

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you allergic or have you had a reaction to:

a. Local anesthetics No Yes
b. Penicillin No Yes
c. Aspirin, Ibuprofen or Tylenol No Yes
d. Codeine, Valium or sedatives No Yes
e. Latex or Metals No Yes
f. Other (please specify)__________________________

For the following questions circle yes or no.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	High Blood Pressure	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Low Blood Pressure	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Thyroid Disease	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Recurrent Illnesses	No	Yes
Heart Stent? When placed?	No	Yes	Do you use tobacco?	No	Yes

Signature:____

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First Name ___________________________ Last Name _____________________________ MI _____________

Sex □ M □F Date of Birth__________ Age: ________ * **Social Security number** ______________________________

MUST HAVE SOCIAL SECURITY NUMBER TO SUBMIT TO DENTAL/MEDICAL INSURANCE

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Employer____ Work Phone _____________________________________

Employer Address_________________________________ City_______________ State_________ Zip___________

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Insurance Company____

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Insurance Company phone number____

FEDERAL EMPLOYEE'S ONLY

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PATIENT OR PARENT/GUARDIAN SIGNATURE: ____

HEALTH HISTORY

Date of last medical exam: ________________ What was this exam for? __________________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: ____

Are you currently under a physician's care? No Yes If yes, nature of care: ______________________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
2. ____
3. ____

Please list any medications you are currently taking and dosages:

1.____
2.____
3.____
4.____

Do you take a Pre-medication prior to dental appointments? NO YES

If "YES", for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES

If so, when did the treatment begin? ______________________ When did the treatment end?______________________________

Are you currently taking any blood thinners? NO YES Which Drug:____

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you allergic or have you had a reaction to:

a. Local anesthetics No Yes
b. Penicillin No Yes
c. Aspirin, Ibuprofen or Tylenol No Yes
d. Codeine, Valium or sedatives No Yes
e. Latex or Metals No Yes
f. Other (please specify)__________________________

For the following questions circle yes or no.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	High Blood Pressure	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Low Blood Pressure	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Thyroid Disease	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS	No	Yes
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Heart Disease, Heart Attack, Heart Surgery	No	Yes	Recurrent Illnesses	No	Yes
Heart Stent? When placed?	No	Yes	Do you use tobacco?	No	Yes

Signature:____

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PATIENT INFORMATION

Date___________________

First Name ____________________________ Last Name ______________________________ MI _____________

Sex □ M □F Date of Birth__________ Age: ________ * **Social Security number** ______________________________

MUST HAVE SOCIAL SECURITY NUMBER TO SUBMIT TO DENTAL/MEDICAL INSURANCE

Address ____

City____ State ________________ ZIP __________________________

Home Phone _____________________________ Cell Phone ____

Email ____________________________________

Marital Status (check one) □Minor □Single □Married □Divorced □Widowed □Separated

Employer____ Work Phone _____________________________________

Employer Address___________________________________ City________________ State_________ Zip___________

Emergency Contact__________________________________ Relationship________________ Phone_____________

MUST BE UPDATED EACH YEAR WITH ALL INFORMATION

DENTAL INSURANCE INFORMATION

Insurance Holder's Name ____________________ Relationship to Insured □Self □Spouse □Child □Other

Insurance Holder's date of birth____________ Insurance Holder's social security number_________________

Insurance Company ____

**The proceeding information will be on your dental insurance card.*

Member ID______________________ Group #________________________ Employer_________________________

Insurance Company Address ____

Insurance Company phone number____

FEDERAL EMPLOYEE'S ONLY

MEDICAL INSURANCE INFORMATION

Insurance Holder's Name _______________________ Relationship to Insured □Self □Spouse □Child □Other

Insured's holder date of birth______________ Insurance Holder's social security_______________

Insurance company_____________________

**The proceeding information will be on your medical card*

Member ID______________________ Group #________________________ Employer_________________________

Insurance Company Address ____

Insurance Company phone number____

We need all correct information to submit to your dental/medical insurance. Incorrect information will be patient responsibility for financial and resubmission.

Assignment of benefits to physician: I authorize the release of medical or other information necessary to process health insurance claims on my behalf. I also request payment of benefits to Deak Medical Dentistry when assignment of benefits is accepted.

Consent to treat: I, the undersigned, authorize medical treatment for **myself** or my minor child, ________________________, as deemed necessary and provided by Dr. Deak and Deak Medical Dentistry

I have read and understand the privacy policy for the office of Deak Medical Dentistry_____________________________.

PATIENT PRINTED NAME: ____DATE________________

PATIENT OR PARENT/GUARDIAN SIGNATURE: ____

HEALTH HISTORY

Date of last medical exam: ________________ What was this exam for? ___________________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: ____

Are you currently under a physician's care? No Yes If yes, nature of care: ______________________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
2. ____
3. ____

Please list any medications you are currently taking and dosages:

1. ____
2. ____
3. ____
4. ____

Do you take a Pre-medication prior to dental appointments? NO YES

If "YES", for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES

If so, when did the treatment begin? _______________________ When did the treatment end?_______________________________

Are you currently taking any blood thinners? NO YES Which Drug:____

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you allergic or have you had a reaction to:

a. Local anesthetics No Yes
b. Penicillin No Yes
c. Aspirin, Ibuprofen or Tylenol No Yes
d. Codeine, Valium or sedatives No Yes
e. Latex or Metals No Yes
f. Other (please specify)__________________________

For the following questions circle yes or no.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	High Blood Pressure	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Low Blood Pressure	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Thyroid Disease	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Recurrent Illnesses	No	Yes
Heart Stent? When placed?	No	Yes	Do you use tobacco?	No	Yes

Signature:____

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MUST FILL OUT ALL THE INFORMATION FULLY.

PATIENT INFORMATION

Date____________________

First Name ____________________________ Last Name ______________________________ MI _____________

Sex □ M □F Date of Birth __________ Age: ________ * Social Security number ______________________________

MUST HAVE SOCIAL SECURITY NUMBER TO SUBMIT TO DENTAL/MEDICAL INSURANCE

Address ____

City ____ State _______________ ZIP _________________________

Home Phone _____________________________ Cell Phone ____

Email ____________________________________

Marital Status (check one) □Minor □Single □Married □Divorced □Widowed □Separated

Employer ____ Work Phone ______________________________________

Employer Address ___________________________________ City ________________ State _________ Zip ___________

Emergency Contact __________________________________ Relationship _________________ Phone ______________

MUST BE UPDATED EACH YEAR WITH ALL INFORMATION

DENTAL INSURANCE INFORMATION

Insurance Holder's Name ____________________ Relationship to Insured □Self □Spouse □Child □Other

Insurance Holder's date of birth ____________ Insurance Holder's social security number _________________

Insurance Company ____

**The proceeding information will be on your dental insurance card.*

Member ID ______________________ Group # ________________________ Employer __________________________

Insurance Company Address ____

Insurance Company phone number ____

FEDERAL EMPLOYEE'S ONLY

MEDICAL INSURANCE INFORMATION

Insurance Holder's Name _______________________ Relationship to Insured □Self □Spouse □Child □Other

Insured's holder date of birth ______________ Insurance Holder's social security ________________

Insurance company _____________________

**The proceeding information will be on your medical card*

Member ID ______________________ Group # ________________________ Employer __________________________

Insurance Company Address ____

Insurance Company phone number ____

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I have read and understand the privacy policy for the office of Deak Medical Dentistry ____________________________.

PATIENT PRINTED NAME: ____ DATE ________________

PATIENT OR PARENT/GUARDIAN SIGNATURE: ____

HEALTH HISTORY

Date of last medical exam: ________________ What was this exam for? __________________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: ____

Are you currently under a physician's care? No Yes If yes, nature of care: ______________________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
2. ____
3. ____

Please list any medications you are currently taking and dosages:

1. ____
2. ____
3. ____
4. ____

Do you take a Pre-medication prior to dental appointments? NO YES

If "YES", for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES

If so, when did the treatment begin? ______________________ When did the treatment end? ______________________________

Are you currently taking any blood thinners? NO YES Which Drug: ____

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you allergic or have you had a reaction to:

a. Local anesthetics No Yes
b. Penicillin No Yes
c. Aspirin, Ibuprofen or Tylenol No Yes
d. Codeine, Valium or sedatives No Yes
e. Latex or Metals No Yes
f. Other (please specify) __________________________

For the following questions circle yes or no.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	High Blood Pressure	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Low Blood Pressure	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Thyroid Disease	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Recurrent Illnesses	No	Yes
Heart Stent? When placed?	No	Yes	Do you use tobacco?	No	Yes

Signature: ____

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PATIENT INFORMATION

Date____________________

First Name ____________________________ Last Name ______________________________ MI _____________

Sex □ M □F Date of Birth__________ Age: ________ * **Social Security number** ____________________________

MUST HAVE SOCIAL SECURITY NUMBER TO SUBMIT TO DENTAL/MEDICAL INSURANCE

Address ____

City____ State ______________ ZIP _________________________

Home Phone _____________________________ Cell Phone _______________________________________

Email ____________________________________

Marital Status (check one) □Minor □Single □Married □Divorced □Widowed □Separated

Employer____ Work Phone ______________________________

Employer Address__________________________________ City______________ State________ Zip__________

Emergency Contact_________________________________ Relationship_______________ Phone_____________

MUST BE UPDATED EACH YEAR WITH ALL INFORMATION

DENTAL INSURANCE INFORMATION

Insurance Holder's Name ____________________ Relationship to Insured □Self □Spouse □Child □Other

Insurance Holder's date of birth____________ Insurance Holder's social security number_________________

Insurance Company ____

**The proceeding information will be on your dental insurance card.*

Member ID______________________ Group #________________________ Employer_________________________

Insurance Company Address ____

Insurance Company phone number____

FEDERAL EMPLOYEE'S ONLY

MEDICAL INSURANCE INFORMATION

Insurance Holder's Name _______________________ Relationship to Insured □Self □Spouse □Child □Other

Insured's holder date of birth______________ Insurance Holder's social security_______________

Insurance company_____________________

**The proceeding information will be on your medical card*

Member ID______________________ Group #________________________ Employer_________________________

Insurance Company Address ____

Insurance Company phone number____

****We need all correct information to submit to your dental/medical insurance. Incorrect information will be patient responsibility for financial and resubmission.***

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I have read and understand the privacy policy for the office of Deak Medical Dentistry______________________________.

PATIENT PRINTED NAME: ____DATE________________

PATIENT OR PARENT/GUARDIAN SIGNATURE: ____

HEALTH HISTORY

Date of last medical exam: ________________ What was this exam for? __________________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: ____

Are you currently under a physician's care? No Yes If yes, nature of care: ______________________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
2. ____
3. ____

Please list any medications you are currently taking and dosages:

1. ____
2. ____
3. ____
4. ____

Do you take a Pre-medication prior to dental appointments? NO YES

If "YES", for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES

If so, when did the treatment begin? _______________________ When did the treatment end?______________________________

Are you currently taking any blood thinners? NO YES Which Drug:____

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you allergic or have you had a reaction to:

a. Local anesthetics No Yes
b. Penicillin No Yes
c. Aspirin, Ibuprofen or Tylenol No Yes
d. Codeine, Valium or sedatives No Yes
e. Latex or Metals No Yes
f. Other (please specify)__________________________

For the following questions circle yes or no.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	High Blood Pressure	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Low Blood Pressure	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Thyroid Disease	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Recurrent Illnesses	No	Yes
Heart Stent? When placed?	No	Yes	Do you use tobacco?	No	Yes

Signature:____

Welcome to Deak Medical Dentistry

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MUST FILL OUT ALL THE INFORMATION FULLY.

PATIENT INFORMATION

Date____________________

First Name ____________________ Last Name ____________________ MI __________

Sex □ M □F Date of Birth __________ Age: ________ * **Social Security number** ____________________

MUST HAVE SOCIAL SECURITY NUMBER TO SUBMIT TO DENTAL/MEDICAL INSURANCE

Address ____

City ____________________ State __________ ZIP __________

Home Phone ____________________ Cell Phone ____________________

Email ____________________

Marital Status (check one) □Minor □Single □Married □Divorced □Widowed □Separated

Employer ____________________ Work Phone ____________________

Employer Address ____________________ City __________ State ________ Zip __________

Emergency Contact ____________________ Relationship __________ Phone __________

MUST BE UPDATED EACH YEAR WITH ALL INFORMATION

DENTAL INSURANCE INFORMATION

Insurance Holder's Name ____________________ Relationship to Insured □Self □Spouse □Child □Other

Insurance Holder's date of birth __________ Insurance Holder's social security number __________

Insurance Company ____

**The proceeding information will be on your dental insurance card.*

Member ID ____________________ Group # ____________________ Employer ____________________

Insurance Company Address ____

Insurance Company phone number ____

FEDERAL EMPLOYEE'S ONLY

MEDICAL INSURANCE INFORMATION

Insurance Holder's Name ____________________ Relationship to Insured □Self □Spouse □Child □Other

Insured's holder date of birth __________ Insurance Holder's social security __________

Insurance company ____________________

**The proceeding information will be on your medical card*

Member ID ____________________ Group # ____________________ Employer ____________________

Insurance Company Address ____

Insurance Company phone number ____

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I have read and understand the privacy policy for the office of Deak Medical Dentistry ____________________.

PATIENT PRINTED NAME: ____ DATE __________

PATIENT OR PARENT/GUARDIAN SIGNATURE: ____

HEALTH HISTORY

Date of last medical exam: ________________ What was this exam for? __________________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: ____

Are you currently under a physician's care? No Yes If yes, nature of care: ______________________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
2. ____
3. ____

Please list any medications you are currently taking and dosages:

1. ____
2. ____
3. ____
4. ____

Do you take a Pre-medication prior to dental appointments? NO YES

If "YES", for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES

If so, when did the treatment begin? _______________________ When did the treatment end?______________________________

Are you currently taking any blood thinners? NO YES Which Drug:____

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you allergic or have you had a reaction to:

a. Local anesthetics No Yes
b. Penicillin No Yes
c. Aspirin, Ibuprofen or Tylenol No Yes
d. Codeine, Valium or sedatives No Yes
e. Latex or Metals No Yes
f. Other (please specify)__________________________

For the following questions circle yes or no.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	High Blood Pressure	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Low Blood Pressure	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Thyroid Disease	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Recurrent Illnesses	No	Yes
Heart Stent? When placed?	No	Yes	Do you use tobacco?	No	Yes

Signature:____

Welcome to Deak Medical Dentistry

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PATIENT INFORMATION

Date____________________

First Name ____________________________ Last Name ______________________________ MI _____________

Sex □ M □F Date of Birth __________ Age: ________ * **Social Security number** ______________________________

MUST HAVE SOCIAL SECURITY NUMBER TO SUBMIT TO DENTAL/MEDICAL INSURANCE

Address ____

City ____ State _______________ ZIP _________________________

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Marital Status (check one) □Minor □Single □Married □Divorced □Widowed □Separated

Employer ____ Work Phone _____________________________________

Employer Address ___________________________________ City _______________ State _________ Zip ___________

Emergency Contact __________________________________ Relationship ________________ Phone ______________

MUST BE UPDATED EACH YEAR WITH ALL INFORMATION

DENTAL INSURANCE INFORMATION

Insurance Holder's Name ____________________ Relationship to Insured □Self □Spouse □Child □Other

Insurance Holder's date of birth ____________ Insurance Holder's social security number _________________

Insurance Company ____

**The proceeding information will be on your dental insurance card.*

Member ID ______________________ Group # ________________________ Employer ________________________

Insurance Company Address ____

Insurance Company phone number ____

FEDERAL EMPLOYEE'S ONLY

MEDICAL INSURANCE INFORMATION

Insurance Holder's Name _______________________ Relationship to Insured □Self □Spouse □Child □Other

Insured's holder date of birth ______________ Insurance Holder's social security _______________

Insurance company _____________________

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Member ID ______________________ Group # ________________________ Employer ________________________

Insurance Company Address ____

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PATIENT PRINTED NAME: ____ DATE _______________

PATIENT OR PARENT/GUARDIAN SIGNATURE: ____

HEALTH HISTORY

Date of last medical exam: ________________ What was this exam for? _________________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: ____

Are you currently under a physician's care? No Yes If yes, nature of care: _____________________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
2. ____
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Please list any medications you are currently taking and dosages:

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2. ____
3. ____
4. ____

Do you take a Pre-medication prior to dental appointments? NO YES

If "YES", for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES

If so, when did the treatment begin? ______________________ When did the treatment end?_____________________________

Are you currently taking any blood thinners? NO YES Which Drug:____

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you allergic or have you had a reaction to:

a. Local anesthetics No Yes
b. Penicillin No Yes
c. Aspirin, Ibuprofen or Tylenol No Yes
d. Codeine, Valium or sedatives No Yes
e. Latex or Metals No Yes
f. Other (please specify)_________________________

For the following questions circle yes or no.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
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Heart Disease, Heart Attack, Heart Surgery	No	Yes	Recurrent Illnesses	No	Yes
Heart Stent? When placed?	No	Yes	Do you use tobacco?	No	Yes

Signature:____

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Date____________________

First Name ___________________________ Last Name _____________________________ MI _____________

Sex □ M □F Date of Birth__________ Age: ________ * **Social Security number** ___________________________

MUST HAVE SOCIAL SECURITY NUMBER TO SUBMIT TO DENTAL/MEDICAL INSURANCE

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Employer____ Work Phone _____________________________________

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DENTAL INSURANCE INFORMATION

Insurance Holder's Name ___________________ Relationship to Insured □Self □Spouse □Child □Other

Insurance Holder's date of birth____________ Insurance Holder's social security number_________________

Insurance Company ____

**The proceeding information will be on your dental insurance card.*

Member ID_____________________ Group #_______________________ Employer_________________________

Insurance Company Address ____

Insurance Company phone number____

FEDERAL EMPLOYEE'S ONLY

MEDICAL INSURANCE INFORMATION

Insurance Holder's Name ______________________ Relationship to Insured □Self □Spouse □Child □Other

Insured's holder date of birth______________ Insurance Holder's social security_______________

Insurance company____________________

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PATIENT PRINTED NAME: ____ DATE_______________

PATIENT OR PARENT/GUARDIAN SIGNATURE: ____

HEALTH HISTORY

Date of last medical exam: ________________ What was this exam for? __________________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: ____

Are you currently under a physician's care? No Yes If yes, nature of care: ______________________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
2. ____
3. ____

Please list any medications you are currently taking and dosages:

1. ____
2. ____
3. ____
4. ____

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If so, when did the treatment begin? _______________________ When did the treatment end?______________________________

Are you currently taking any blood thinners? NO YES Which Drug:____

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you allergic or have you had a reaction to:

a. Local anesthetics No Yes
b. Penicillin No Yes
c. Aspirin, Ibuprofen or Tylenol No Yes
d. Codeine, Valium or sedatives No Yes
e. Latex or Metals No Yes
f. Other (please specify)__________________________

For the following questions circle yes or no.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	High Blood Pressure	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Low Blood Pressure	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Thyroid Disease	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Recurrent Illnesses	No	Yes
Heart Stent? When placed?	No	Yes	Do you use tobacco?	No	Yes

Signature:____

Welcome to Deak Medical Dentistry

Please take a few moments to complete this form in its entirety. All information will be considered confidential, and will be released only as allowed through HIPAA regulations, and as considered necessary for treatment, payment, or other health care operations.

MUST FILL OUT ALL THE INFORMATION FULLY.

PATIENT INFORMATION

Date___________________

First Name ___________________________ Last Name _____________________________ MI _____________

Sex □ M □F Date of Birth__________ Age: ________ * **Social Security number** ______________________________

MUST HAVE SOCIAL SECURITY NUMBER TO SUBMIT TO DENTAL/MEDICAL INSURANCE

Address ____

City____ State _______________ ZIP _________________________

Home Phone ____________________________ Cell Phone _______________________________________

Email ___________________________________

Marital Status (check one) □Minor □Single □Married □Divorced □Widowed □Separated

Employer____ Work Phone _____________________________________

Employer Address _________________________________ City _______________ State _________ Zip ___________

Emergency Contact ________________________________ Relationship ________________ Phone ______________

MUST BE UPDATED EACH YEAR WITH ALL INFORMATION

DENTAL INSURANCE INFORMATION

Insurance Holder's Name ____________________ Relationship to Insured □Self □Spouse □Child □Other

Insurance Holder's date of birth____________ Insurance Holder's social security number_________________

Insurance Company ____

**The proceeding information will be on your dental insurance card.*

Member ID_____________________ Group #_______________________ Employer ________________________

Insurance Company Address ____

Insurance Company phone number ____

FEDERAL EMPLOYEE'S ONLY

MEDICAL INSURANCE INFORMATION

Insurance Holder's Name ______________________ Relationship to Insured □Self □Spouse □Child □Other

Insured's holder date of birth______________ Insurance Holder's social security_______________

Insurance company____________________

**The proceeding information will be on your medical card*

Member ID_____________________ Group #_______________________ Employer ________________________

Insurance Company Address ____

Insurance Company phone number ____

We need all correct information to submit to your dental/medical insurance. Incorrect information will be patient responsibility for financial and resubmission.

Assignment of benefits to physician: I authorize the release of medical or other information necessary to process health insurance claims on my behalf. I also request payment of benefits to Deak Medical Dentistry when assignment of benefits is accepted.

Consent to treat: I, the undersigned, authorize medical treatment for **myself** or my minor child, _______________________, as deemed necessary and provided by Dr. Deak and Deak Medical Dentistry

I have read and understand the privacy policy for the office of Deak Medical Dentistry____________________________.

PATIENT PRINTED NAME: ____ DATE _______________

PATIENT OR PARENT/GUARDIAN SIGNATURE: ____

HEALTH HISTORY

Date of last medical exam: ________________ What was this exam for? __________________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: ____

Are you currently under a physician's care? No Yes If yes, nature of care: ______________________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
2. ____
3. ____

Please list any medications you are currently taking and dosages:

1. ____
2. ____
3. ____
4. ____

Do you take a Pre-medication prior to dental appointments? NO YES

If "YES", for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES

If so, when did the treatment begin? _______________________ When did the treatment end?______________________________

Are you currently taking any blood thinners? NO YES Which Drug:____

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you allergic or have you had a reaction to:

a. Local anesthetics No Yes
b. Penicillin No Yes
c. Aspirin, Ibuprofen or Tylenol No Yes
d. Codeine, Valium or sedatives No Yes
e. Latex or Metals No Yes
f. Other (please specify)__________________________

For the following questions circle yes or no.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	High Blood Pressure	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Low Blood Pressure	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Thyroid Disease	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Recurrent Illnesses	No	Yes
Heart Stent? When placed?	No	Yes	Do you use tobacco?	No	Yes

Signature:____

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Sex □ M □F Date of Birth__________ Age: ________ * **Social Security number** _____________________________
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Address ____

City ____ State _______________ ZIP _________________________

Home Phone ____________________________ Cell Phone ______________________________________

Email ___________________________________

Marital Status (check one) □Minor □Single □Married □Divorced □Widowed □Separated

Employer ____ Work Phone _____________________________________

Employer Address _________________________________ City _______________ State _________ Zip __________

Emergency Contact ________________________________ Relationship ________________ Phone _____________

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DENTAL INSURANCE INFORMATION

Insurance Holder's Name ____________________ Relationship to Insured □Self □Spouse □Child □Other

Insurance Holder's date of birth ____________ Insurance Holder's social security number _________________

Insurance Company ____

**The proceeding information will be on your dental insurance card.*

Member ID _____________________ Group # _________________________ Employer _________________________

Insurance Company Address ____

Insurance Company phone number ____

FEDERAL EMPLOYEE'S ONLY

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Insurance company _____________________

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Insurance Company phone number ____

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I have read and understand the privacy policy for the office of Deak Medical Dentistry _____________________________.

PATIENT PRINTED NAME: ____ DATE _______________

PATIENT OR PARENT/GUARDIAN SIGNATURE: ____

HEALTH HISTORY

Date of last medical exam: ________________ What was this exam for? __________________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: ____

Are you currently under a physician's care? No Yes If yes, nature of care: ______________________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
2. ____
3. ____

Please list any medications you are currently taking and dosages:

1. ____
2. ____
3. ____
4. ____

Do you take a Pre-medication prior to dental appointments? NO YES

If "YES", for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES

If so, when did the treatment begin? _______________________ When did the treatment end?______________________________

Are you currently taking any blood thinners? NO YES Which Drug:____

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you allergic or have you had a reaction to:

a. Local anesthetics No Yes
b. Penicillin No Yes
c. Aspirin, Ibuprofen or Tylenol No Yes
d. Codeine, Valium or sedatives No Yes
e. Latex or Metals No Yes
f. Other (please specify)__________________________

For the following questions circle yes or no.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	High Blood Pressure	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Low Blood Pressure	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Thyroid Disease	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Recurrent Illnesses	No	Yes
Heart Stent? When placed?	No	Yes	Do you use tobacco?	No	Yes

Signature:____

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PATIENT INFORMATION

Date___________________

First Name _____________________________ Last Name _______________________________ MI ____________

Sex □ M □F Date of Birth__________ Age: ________ * Social Security number ______________________________

MUST HAVE SOCIAL SECURITY NUMBER TO SUBMIT TO DENTAL/MEDICAL INSURANCE

Address ____

City ____ State _______________ ZIP _________________________

Home Phone ______________________________ Cell Phone ____

Email ____________________________________

Marital Status (check one) □Minor □Single □Married □Divorced □Widowed □Separated

Employer____ Work Phone ________________________________

Employer Address_________________________________ City_______________ State_________ Zip___________

Emergency Contact ________________________________ Relationship ________________ Phone ______________

MUST BE UPDATED EACH YEAR WITH ALL INFORMATION

DENTAL INSURANCE INFORMATION

Insurance Holder's Name ____________________ Relationship to Insured □Self □Spouse □Child □Other

Insurance Holder's date of birth____________ Insurance Holder's social security number_________________

Insurance Company ____

**The proceeding information will be on your dental insurance card.*

Member ID______________________ Group #________________________ Employer______________________

Insurance Company Address ____

Insurance Company phone number____

FEDERAL EMPLOYEE'S ONLY

MEDICAL INSURANCE INFORMATION

Insurance Holder's Name _______________________ Relationship to Insured □Self □Spouse □Child □Other

Insured's holder date of birth______________ Insurance Holder's social security_______________

Insurance company_____________________

**The proceeding information will be on your medical card*

Member ID______________________ Group #________________________ Employer______________________

Insurance Company Address ____

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I have read and understand the privacy policy for the office of Deak Medical Dentistry_____________________________.

PATIENT PRINTED NAME: ____ DATE________________

PATIENT OR PARENT/GUARDIAN SIGNATURE: ____

HEALTH HISTORY

Date of last medical exam: ________________ What was this exam for? __________________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: ____

Are you currently under a physician's care? No Yes If yes, nature of care: ______________________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
2. ____
3. ____

Please list any medications you are currently taking and dosages:

1. ____
2. ____
3. ____
4. ____

Do you take a Pre-medication prior to dental appointments? NO YES

If "YES", for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES

If so, when did the treatment begin? _______________________ When did the treatment end?______________________________

Are you currently taking any blood thinners? NO YES Which Drug:____

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you allergic or have you had a reaction to:

a. Local anesthetics No Yes
b. Penicillin No Yes
c. Aspirin, Ibuprofen or Tylenol No Yes
d. Codeine, Valium or sedatives No Yes
e. Latex or Metals No Yes
f. Other (please specify)__________________________

For the following questions circle yes or no.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	High Blood Pressure	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Low Blood Pressure	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Thyroid Disease	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Recurrent Illnesses	No	Yes
Heart Stent? When placed?	No	Yes	Do you use tobacco?	No	Yes

Signature:____

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PATIENT INFORMATION

Date____________________

First Name ____________________________ Last Name ______________________________ MI _____________

Sex □ M □F Date of Birth__________ Age: _________ * **Social Security number** ______________________________

MUST HAVE SOCIAL SECURITY NUMBER TO SUBMIT TO DENTAL/MEDICAL INSURANCE

Address ____

City____ State ________________ ZIP _________________________

Home Phone _____________________________ Cell Phone ____

Email ____________________________________

Marital Status (check one) □Minor □Single □Married □Divorced □Widowed □Separated

Employer____ Work Phone______________________________________

Employer Address___________________________________ City_______________ State_________ Zip___________

Emergency Contact__________________________________ Relationship________________ Phone______________

MUST BE UPDATED EACH YEAR WITH ALL INFORMATION

DENTAL INSURANCE INFORMATION

Insurance Holder's Name ____________________ Relationship to Insured □Self □Spouse □Child □Other

Insurance Holder's date of birth____________ Insurance Holder's social security number_________________

Insurance Company____

**The proceeding information will be on your dental insurance card.*

Member ID_____________________ Group #_________________________ Employer________________________

Insurance Company Address ____

Insurance Company phone number____

FEDERAL EMPLOYEE'S ONLY

MEDICAL INSURANCE INFORMATION

Insurance Holder's Name _______________________ Relationship to Insured □Self □Spouse □Child □Other

Insured's holder date of birth______________ Insurance Holder's social security_______________

Insurance company_____________________

**The proceeding information will be on your medical card*

Member ID_____________________ Group #_________________________ Employer________________________

Insurance Company Address ____

Insurance Company phone number____

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I have read and understand the privacy policy for the office of Deak Medical Dentistry_____________________________.

PATIENT PRINTED NAME: ____DATE_______________

PATIENT OR PARENT/GUARDIAN SIGNATURE: ____

HEALTH HISTORY

Date of last medical exam: ________________ What was this exam for? __________________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: ____

Are you currently under a physician's care? No Yes If yes, nature of care: ______________________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
2. ____
3. ____

Please list any medications you are currently taking and dosages:

1. ____
2. ____
3. ____
4. ____

Do you take a Pre-medication prior to dental appointments? NO YES

If "YES", for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES

If so, when did the treatment begin? _______________________ When did the treatment end?______________________________

Are you currently taking any blood thinners? NO YES Which Drug:____

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you allergic or have you had a reaction to:

a. Local anesthetics No Yes
b. Penicillin No Yes
c. Aspirin, Ibuprofen or Tylenol No Yes
d. Codeine, Valium or sedatives No Yes
e. Latex or Metals No Yes
f. Other (please specify)__________________________

For the following questions circle yes or no.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	High Blood Pressure	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Low Blood Pressure	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Thyroid Disease	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
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Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Recurrent Illnesses	No	Yes
Heart Stent? When placed?	No	Yes	Do you use tobacco?	No	Yes

Signature:____

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Insurance Holder's date of birth____________ Insurance Holder's social security number_________________

Insurance Company____

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Member ID______________________ Group #________________________ Employer_________________________

Insurance Company Address ____

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HEALTH HISTORY

Date of last medical exam: ________________ What was this exam for? ___________________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: ____

Are you currently under a physician's care? No Yes If yes, nature of care: ______________________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
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If so, when did the treatment begin? _______________________ When did the treatment end? ______________________________

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Women: Are you pregnant? No Yes

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Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Thyroid Disease	No	Yes
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Heart Stent? When placed?	No	Yes	Do you use tobacco?	No	Yes

Signature: ____

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FEDERAL EMPLOYEE'S ONLY

MEDICAL INSURANCE INFORMATION

Insurance Holder's Name _______________________ Relationship to Insured □Self □Spouse □Child □Other

Insured's holder date of birth______________ Insurance Holder's social security_______________

Insurance company____________________

**The proceeding information will be on your medical card*

Member ID_____________________ Group #________________________ Employer__________________________

Insurance Company Address ____

Insurance Company phone number____

We need all correct information to submit to your dental/medical insurance. Incorrect information will be patient responsibility for financial and resubmission.

Assignment of benefits to physician: I authorize the release of medical or other information necessary to process health insurance claims on my behalf. I also request payment of benefits to Deak Medical Dentistry when assignment of benefits is accepted.

Consent to treat: I, the undersigned, authorize medical treatment for **myself** or my minor child, _______________________, as deemed necessary and provided by Dr. Deak and Deak Medical Dentistry

I have read and understand the privacy policy for the office of Deak Medical Dentistry____________________________.

PATIENT PRINTED NAME: ____DATE________________

PATIENT OR PARENT/GUARDIAN SIGNATURE: ____

HEALTH HISTORY

Date of last medical exam: ________________ What was this exam for? _________________________

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: ____

Are you currently under a physician's care? No Yes If yes, nature of care: _____________________________

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. ____
2. ____
3. ____

Please list any medications you are currently taking and dosages:

1. ____
2. ____
3. ____
4. ____

Do you take a Pre-medication prior to dental appointments? NO YES

If "YES", for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES

If so, when did the treatment begin? ______________________ When did the treatment end?_____________________________

Are you currently taking any blood thinners? NO YES Which Drug:____

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

Are you allergic or have you had a reaction to:

a. Local anesthetics No Yes
b. Penicillin No Yes
c. Aspirin, Ibuprofen or Tylenol No Yes
d. Codeine, Valium or sedatives No Yes
e. Latex or Metals No Yes
f. Other (please specify)_________________________

For the following questions circle yes or no.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	High Blood Pressure	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Low Blood Pressure	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Thyroid Disease	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Recurrent Illnesses	No	Yes
Heart Stent? When placed?	No	Yes	Do you use tobacco?	No	Yes

Signature:____

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MUST FILL OUT ALL THE INFORMATION FULLY.

PATIENT INFORMATION

Date____________________

First Name ____________________________ Last Name ______________________________ MI _____________

Sex □ M □F Date of Birth__________ Age: ________ * Social Security number ______________________________

MUST HAVE SOCIAL SECURITY NUMBER TO SUBMIT TO DENTAL/MEDICAL INSURANCE

Address ____

City ____ State ______________ ZIP _________________________

Home Phone _____________________________ Cell Phone ____

Email ___________________________________

Marital Status (check one) □Minor □Single □Married □Divorced □Widowed □Separated

Employer ____ Work Phone _____________________________________

Employer Address __________________________________ City _______________ State ________ Zip ___________

Emergency Contact _________________________________ Relationship ________________ Phone ______________

MUST BE UPDATED EACH YEAR WITH ALL INFORMATION

DENTAL INSURANCE INFORMATION

Insurance Holder's Name ____________________ Relationship to Insured □Self □Spouse □Child □Other

Insurance Holder's date of birth____________ Insurance Holder's social security number_________________

Insurance Company ____

**The proceeding information will be on your dental insurance card.*

Member ID______________________ Group #________________________ Employer__________________________

Insurance Company Address ____

Insurance Company phone number____

FEDERAL EMPLOYEE'S ONLY

MEDICAL INSURANCE INFORMATION

Insurance Holder's Name _______________________ Relationship to Insured □Self □Spouse □Child □Other

Insured's holder date of birth______________ Insurance Holder's social security_______________

Insurance company_____________________

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PATIENT OR PARENT/GUARDIAN SIGNATURE: ____

HEALTH HISTORY

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If yes, reason: ____

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1. ____
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Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES

If so, when did the treatment begin? _____________________ When did the treatment end?____________________________

Are you currently taking any blood thinners? NO YES Which Drug:_______________________________________

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you a nursing mother? No Yes

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For the following questions circle yes or no.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	High Blood Pressure	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Low Blood Pressure	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Thyroid Disease	No	Yes
Glaucoma	No	Yes	Slow-Healing Mouth Sores	No	Yes
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Address ____

City_________________________________ State ____________ ZIP ____________________

Home Phone _______________________ Cell Phone ________________________________

Email ___________________________

Marital Status (check one) □Minor □Single □Married □Divorced □Widowed □Separated

Employer_________________________________ Work Phone ______________________________

Employer Address____________________________ City____________ State_______ Zip__________

Emergency Contact___________________________ Relationship_____________ Phone____________

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DENTAL INSURANCE INFORMATION

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Insurance Holder's date of birth__________ Insurance Holder's social security number______________

Insurance Company ____

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Insurance Company Address ____

Insurance Company phone number_______________________________________

FEDERAL EMPLOYEE'S ONLY

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