PATIENT INFORMATION FORM

Name: _____DOB: _____Age___
Home Phone: _____Wk Phone:_____
Cell Phone_____Email Address:_____
Home Address:_____
City:_____ State:_____Zip Code:_____
Social Security #:_____STUDENT____YES ____NO
Who is responsible for this bill?_____

Employer Information: Employer Name and Address:

_____
Employer Phone: _____

Primary Care or Referring Physician/Dentist:_____
Phone: _____

Whom may we contact in the case of an emergency? _____
Phone:_____Relationship to Patient_____

Insurance Information
Name of Insured: _____
Relationship to Patient:_____
Birthdate: _____ Social Security Number: _____
Name of employer: _____
Office Phone: _____
Insurance Company: _____ Group #:_____
Employer/ID# _____
Insurance Co address: _____
City/State: _____ _____ Zip:_____
Do you have Secondary Insurance? ___Yes ___No
Name of Insured:_____
Relationship to Patient: _____
Birthdate: _____ Social Security Number: _____
Name of employer: _____
Office Phone: _____
Insurance Company: _____ Group #: _____
Employer/ID# _____
Address: _____ City/State: _____ _____ Zip: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information. This information will be kept confidential.

_____ _____
SIGNATURE DATE

MEDICAL HISTORY

Are you taking any of the following medications for treatment of Osteoporosis or Cancer?__YES__NO

Etidronate(Didronel) Tiludronate(Skelid) Alendronate(Fosamax) Risedronate(Actonel)
Ibandronate(Boniva) Pamidronate(Aredia) Zoledronate(Zometa)

Please List All Medications You are Taking:

Are you Allergic to anything: __YES __NO If yes, please list:_____

_____

Have you ever been hospitalized? ___YES __NO If YES, Why?_____

Are you currently under the care of a physician? ___YES ___NO

Name of attending physician:_____

Do you or have you ever had any of the following (check all that apply)

__Heart Disease __High Blood Pressure __Lung Disease __Diabetes

__Alzheimer's __Rheumatic Fever __Kidney Disease __Thyroid Disease

__Seizures __Heart Murmur __Liver Disease __Tuberculosis

__Venereal Disease __Asthma __Hepatitis/Type ____

__Bleeding Disorder __HIV Positive/AIDS __Cancer __Mental or Emotional Disorders

__Radiation treatment to face or neck

WOMEN ONLY: Are you Pregnant? __Yes ___No Nursing? ___Yes ___No

Reason for seeking treatment today? _____

In your opinion what is your current state of health? _____

IF YOU ARE GOING TO SLEEP PLEASE SIGN:

I CERTIFY THAT I HAVE NOT HAD ANYTHING TO EAT OR DRINK IN THE LAST (6) HOURS.

Signature (parent, if a minor) _____Date:_____

Do you need a work/school excuse? ___ YES ___NO