Welcome Back

PATIENT & INSURANCE INFORMATION...

Date _____ Patient's Name _____ (FIRST NAME) _____ (LAST NAME)

Date of Birth _____ Social Security Number _____

Has there been any change in your address or telephone numbers? ❑ No ❑ Yes, please describe the changes below.

_____

_____

Has there been any change in your insurance information? ❑ No ❑ Yes, please describe the changes below.

_____

_____

MEDICAL HISTORY...

Are you in good health? ❑ Yes ❑ No • Height _____ Weight _____

Has there been any change in your medical condition since you last visit? ❑ No ❑ Yes, please describe the changes below.

_____

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
❑	❑	Rheumatic fever	❑	❑	Mental health problems	❑	❑	Abnormal bleeding	❑	❑	Kidney trouble
❑	❑	High blood pressure	❑	❑	Problems with immune system *(possibly from med. / surg.)*	❑	❑	Bleeding tendency	❑	❑	Sexually transmitted diseases
❑	❑	Low blood pressure				❑	❑	Blood transfusion	❑	❑	Contagious diseases
❑	❑	Mitral valve prolapse	❑	❑	Delay in healing	❑	❑	Blood disorder	❑	❑	Infectious mononucleosis
❑	❑	Heart murmur	❑	❑	Hay fever / Sinus problems	❑	❑	Bruise easily	❑	❑	Swollen ankles
❑	❑	Chest pain / Angina	❑	❑	Snoring	❑	❑	Eye disease / Glaucoma	❑	❑	Arthritis / Joint disease
❑	❑	Heart attack(s)	❑	❑	Sleep apnea / CPAP	❑	❑	Jaundice / Liver disease	❑	❑	Prosthetic implant
❑	❑	Irregular heart beat	❑	❑	Respiratory problems	❑	❑	Hepatitis	❑	❑	Joint replacement
❑	❑	Cardiac pacemaker	❑	❑	Tuberculosis	❑	❑	Gallbladder trouble	❑	❑	Osteoporosis / Osteopenia
❑	❑	Heart surgery	❑	❑	Emphysema	❑	❑	Fainting spells	❑	❑	Osteonecrosis
❑	❑	Damaged heart valves	❑	❑	Do you smoke or vape *If so, how much a day* _____	❑	❑	Convulsions / Epilepsy	❑	❑	Acid reflux
❑	❑	Pneumonia / Bronchitis / Chronic cough				❑	❑	Stroke	❑	❑	GI troubles / ulcers / IBS / Colitis
❑	❑	Chronic fatigue / Night sweat	❑	❑	Do you use chewing tobacco	❑	❑	Thyroid trouble	❑	❑	Tumor or growth
❑	❑	Trouble climbing 1-2 flights of stairs	❑	❑	A history of marijuana or other drug use	❑	❑	Diabetes	❑	❑	Cancer / Radiation / Chemotherapy
❑	❑	Anemia				❑	❑	Low blood sugar	❑	❑	Are you on a diet
❑	❑	Asthma	❑	❑	A history of alcohol abuse	❑	❑	Are you on dialysis	❑	❑	Contact lenses

MEDICATION & ALLERGIES...

Are you now taking:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Nerve pills	❑	❑	Pain killers (including aspirin)	❑	❑	Muscle relaxers	❑	❑	Stimulants
❑	❑	Diet pills	❑	❑	Tranquilizers	❑	❑	Insulin	❑	❑	Antidepressants
									❑	❑	Blood thinners (Coumadin,Aspirin)
									❑	❑	Are you taking, or have you ever taken, any bone density meds., RANKL inhibitors or bisphosphonates, such as Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia Reclast, or Evista in the past the past 12 years.

Please list any other medication(s) you are taking (including natural, herbal, or homeopathic products):

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

Are you allergic to, or had a reaction to:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Penicillin	❑	❑	Sulfa drugs	❑	❑	Local anesthetic (numbing med)	❑	❑	Amoxicillin
❑	❑	Sodium pentothal / Valium / other tranq.	❑	❑	Aspirin	❑	❑	Codeine or other narcotics	❑	❑	Latex
❑	❑	Soy	❑	❑	Eggs / Yolk	❑	❑	Sulfites	❑	❑	Do you have any known allergies

Please list any other medication or antibiotic you are allergic to: _____

Please list any allergies other than drug allergies: _____

1-4 below for women only: *(Women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? ❑ Yes ❑ No

2) Expected delivery date: _____

3) Are you nursing? ❑ Yes ❑ No

4) Are you taking birth control pills: ❑ Yes ❑ No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Reviewed by**

X _____ **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X _____ **Signature of patient** *(Parent or Guardian if Minor)*

X _____ **Date**