PATIENT HISTORY

Name: _____
Mailing Address: _____
E-mail Address: _____
Cell #: _____ **Work#:** _____ **Home#:** _____
Birthdate: _____ **SSN:** _____ **Sex:** _____
Employer: _____ **Occupation:** _____
Employer Address: _____

Name of Spouse: _____
Spouse's Birthdate: _____ **Spouse's SSN:** _____
Spouse's Employer: _____

Do you have dental insurance? (circle one) Yes No
Primary Ins Co: _____ **Secondary Ins Co:** _____

NOTIFY IN CASE OF EMERGENCY:
Name: _____ **Phone #:** _____
Physician's Name: _____ **Phone#:** _____
List medication allergies: _____
List medications taken regularly: _____
_____
Do you take Biphosphonates (Boniva, Fosamax, Prolia, etc)? _____
Do you take blood thinners? _____ **Name of blood thinner:** _____
Have you had recent surgery? _____ **If yes, describe** _____
Are you pregnant? _____

Do you have a history of any of the following?
Anemia _____
Artificial heart valve _____ **Artificial joint** _____ **Asthma** _____
Bleeding disorder _____ **Diabetes** _____ **Epilepsy** _____
Heart Disease _____ **Heart Murmur** _____ **Hepatitis** _____
High BP _____ **HIV** _____ **Infective Endocarditis** _____
Latex allergy_____ **Rheumatic Fever** _____ **TB** _____
Other _____

I give my informed consent to any advisable and necessary dental procedure, medications, or anesthetics that are administered to me by Monticello Family Dentistry or the staff. I also release the doctors from any unforeseen complications that may arise.

Signature: _____ **Date:** _____