ROSE & ROSE, DDS, PA

DATE___________________

Patient Name____ Date of Birth ____________________

Nickname____________________________ Sex: M F Age______________

Mailing Address____

Physical Address____

City____ State_______________ Zip_______________

Phone Numbers: Home_____________________ Work______________________ Cell__________________

Employer____

Spouse/Parent Name____ Phone__________________

Closest Relative or Friend NOT Living With You ___________________________ Phone___________________

Social Security Number_____________________________ (You must provide this number if we will be filing insurance on your behalf)

Circle Method of Payment: CASH/CHECK CREDIT/DEBIT CARD INSURANCE

HEALTH HISTORY:

General Physician (Internal Medicine, Family Medicine, Pediatrician, OB/GYN)_____________________________________

Orthopedic Physician (Bone and Joint Doctor)____

Cardiologist (Heart Doctor)____

Oncologist (Cancer Doctor)____

CIRCLE if you have or have ever had any of the following conditions:

AIDS/HIV
Hepatitis (Type_______)

Osteoporosis
Back Problems

Blood Disease
Bleeding Abnormally

Cancer (Type_____________)
Chemotherapy
Radiation Treatment

Epilepsy
Asthma
Sinus Trouble

Kidney Disease
Liver Disease

Heart Problems
Heart Attack (Date___________)
Stents
High Blood Pressure
Congenital Heart Lesions
Pacemaker/Defibrillator

Stroke (Date____________)
Diabetes
Circulatory Problems/Clots
Emphysema

PLEASE TURN PAGE OVER

Do you have any of the following? If so, please **circle and complete** the requested information.

(**Premedication with an antibiotic may be required)

**Artificial Heart Valves

**Artificial Joints (Type______________) (Date_________________)

**Organ Transplant (Type________________) (Date________________)

Women: Are you pregnant?____________ Nursing?___________ Taking Birth Control Pills?_____________

MEDICATIONS:

Please List All Medications: ____

____

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Have you **<u>ever</u>** taken any of the following medications? **(circle)** Fosamax Boniva Actonel Reclast Aredia Zometa

Do you **<u>currently</u>** take any of the following medications? **(circle)** Coumadin Pradaxa Xarelto Lovenox Aggrenox Plavix

ALLERGIES: (Circle)

Aspirin Motrin/Ibuprofen Penicillin Codeine Tylenol Sulfa Drugs Latex

Other___________________________

PREVIOUS DENTIST:______________________________________ City___________________ State____________

Whom can we thank for referring you to our office?____

Please list **all** individuals to whom you will allow us to provide "Protected Health Information":

(e.g. – discuss health care matters, release dental records to them, call for emergency purposes, etc.)

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I certify that the above information is complete and accurate to the best of my knowledge. I understand that I am personally responsible for the information that is provided as well as for informing Rose and Rose, DDS, PA of any changes in my personal information, medical history, medications, or allergies.

Signature____ Date____________________