



WELCOME!

Please complete the following Patient Information and Medical History Form in full and bring it with you to your first appointment or send it to aaronmanosdds@gmail.com
We look forward to meeting you!

NAME: _____

HOME ADDRESS: _____

HOME PHONE: _____

CELL PHONE: _____

EMAIL ADDRESS: _____

DATE OF BIRTH: _____

MARITAL STATUS: _____

EMPLOYER NAME: _____

OCCUPATION: _____

DENTAL INSURANCE INFORMATION:

SUBSCRIBER NAME: _____

RELATION TO PATIENT: _____

SUBSCRIBER DOB: _____

INSURANCE COMPANY NAME & PHONE NUMBER:

GROUP NAME: _____

GROUP ID#: _____

MEMBER ID #: _____

Primary Physician Name:	Physician Phone:
Pharmacy Name & Location:	Pharmacy Phone:
Emergency Contact:	Emergency Contact Phone:

WHERE DID YOU HEAR ABOUT US? (CHECK AS MANY AS APPLY)

- ☐ Internet Search
☐ Brochures or Signage

- ☐ Patient Referral: (name) _____
☐ Other: _____

TODAY'S DATE: _____

SIGNATURE: _____

Medical History

Have you been hospitalized or had a major operation in the last year?

☐ NO ☐ YES

Have you ever had a serious head or neck injury?

☐ NO ☐ YES

Do you have any artificial joints, valves, or implants?

☐ NO ☐ YES: _____

Are you under the care of any other medical specialist?

☐ NO ☐ YES

If Yes, please provide their names / phone numbers:

Patients with artificial joints, valves, or implants/prosthetics may, at the discretion of the surgeon, require antibiotic pre-medication prior to dental treatment (including cleanings).

Has your surgeon required antibiotic pre-medication?

☐ NO ☐ YES ☐ I Don't Know

Have you ever taken bisphosphonates or anti-resorptive drugs (Fosamax, Boniva, Reclast, Prolia, etc)?

☐ NO ☐ YES, taken orally ☐ YES, via injection ☐ I Don't Know

Please list any current medications and dosage/instructions:

Please list any allergies (penicillin, sulfa, etc.):

Do you have any of the following medical conditions?

Blood Thinners

☐ NO ☐ YES

Osteoporosis

☐ NO ☐ YES

Cancer

☐ NO ☐ YES

Pregnancy or Nursing

☐ NO ☐ YES

Diabetes

☐ NO ☐ YES

Radiation Treatment

☐ NO ☐ YES

	No	Yes		No	Yes		No	Yes
Alzheimer's disease	☐	☐	Heart Attack/Failure	☐	☐	Severe Vision Impairment	☐	☐
Angina	☐	☐	Heart Murmur	☐	☐	Sickle Cell Disease	☐	☐
Arthritis/Gout	☐	☐	Heart Pace Maker	☐	☐	Sinus Trouble	☐	☐
Blood Transfusion	☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐
Breathing Problem/Asthma	☐	☐	Irregular Heartbeat	☐	☐	Thyroid Disease	☐	☐
Drug/Alcohol Addiction	☐	☐	Kidney Disease	☐	☐	Tonsillitis	☐	☐
Epilepsy or Seizures	☐	☐	Liver Disease	☐	☐	Tuberculosis	☐	☐
Gastrointestinal Disease	☐	☐	Low Blood Pressure	☐	☐	Other/Not Listed?	☐	☐
GERD/Reflux	☐	☐	Mitral Valve Prolapse	☐	☐	If Yes, please describe below		
			Psychiatric Care	☐	☐			

Do you use Tobacco?

☐ NO ☐ YES: what kind and how much? _____

TODAY'S DATE: _____

SIGNATURE: _____