# PATIENT INFORMATION – Dr. Stephen M. Friedman's dental office

Patient's name _____ Phone _____
Last First Initial

Prefer to be addressed as _____ Work Phone _____

Address _____ Cell phone _____
Number and Street City Zip Code

Date of Birth _____ Sex M F Single Married Social Security # _____

Occupation _____ E-mail _____

Business Address/Employer _____

Spouse/Parent (Circle one) _____ Occupation _____

Business Address/Employer _____ Work phone _____

Person responsible for account _____ **REFERRED BY** _____

Emergency contact? _____ Phones _____

Address _____

**Current medical doctor** _____ **Phone** _____

Date and reason for last visit _____

Hospitalized within the last 2 years? Yes No Reason _____

Medications taken during the past year ? _____

_____

**Allergies to penicillin or other medications?** _____

**Bisphosphonate medications?** (using now or previously??) fosomax actonel bonvia skelid didronel aredia zometa bonefos

Have you ever tested HIV Positive? Yes No Do you use tobacco products? Smoke Chew

Last visit to the dentist? _____ Reason? _____

**Current dental problem?** _____

Please **CIRCLE** any of the following that you have had:

| | | | |
|---|---|---|---|
| Heart trouble | Any blood disease | Tuberculosis | Diabetes I or II |
| Heart murmur | Cancer | Asthma | Anemia |
| Stroke | Bleeding problems | Radiation treatment | Ulcers |
| High blood pressure | Arthritis | Jaundice | Psychiatric treatment |
| Rheumatic fever | Glaucoma | Epilepsy | Sinus trouble |
| Cardiac pacemaker | Persistent cough | Hepatitis A, B, C | allergies to metal |
| Mitral Valve Prolapse | Alcoholism | Gastric reflux | Kidney disease |

Joint surgery or replacement within the last two (2) years? _____ Date _____

Any medical concerns not mentioned? _____

***PREGNANCY:*** ***Are you pregnant now?*** Yes No ***Nursing?*** Yes No ***Taking birth control medication?*** Yes No

PLEASE CONTINUE ON REVERSE SIDE

**DENTAL INSURANCE?** Yes No Name of Insurance Company _____

Insured's SS# or Member ID _____ Group # _____ Insured's DOB _____

Ins company address _____

Dual Coverage ? Y N Insured's name _____

Insured's SS# or Member ID _____ Group # _____ Insured's DOB _____

Insurance Co name _____

Insurance Co. address

_____

I hereby authorize this dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

**Signature** _____

**Date** _____

(*parent/guardian if patient is a minor*)