## WELCOME TO OUR PRACTICE TODAY'S DATE\_\_\_\_\_

NAME					Social Security No		
MAILING AD	DDRESS					State Zip	
What name would you like to be called?			D.L.#			Marital Status	
Spouse's Na	ame	E-mail address				Employer	
VHO MAY W	E THANK FOR REF	ERRING YOU TO OUR OFFIC	CE				
hones: Hor	me	Work		Fax			
Cell	I	Pager		Other			
ACCOUNT F	RESPONSIBILITY	if someone other than you	rself: NAME _				
heir Social Security No		Birth	date	Mailing /	Addre	ess	
Daytime Pho	one	D.L.#					
		INSU	JRANCE INFO	RMATION			
nsured's Name		Member	ID No			Employer	
าร Co		Group #	Insured's Birthd		te	Phone#	
nsurance Co	o. Address						
mergency	contact:	F	Relation		F	Phone:	
IEALTH HIS	STORY (please cl	neck if you have or had a	ny of the follow	wing:)			
_YesN	No Are you in go	ood health?		Yes _	_No	TB, asthma, or lung disease?	
_YesN	No Has your he	alth changed in the last yea		Yes _	_No	Diabetes	
_YesN		shortness of breath		Yes _		Tumors, cancer	
_YesN Yes N	No Bleeding pro	blems, bruise easily		Yes _		Radiation treatment	
_YesN YesN		ringing in ears stiffness, arthritis		Yes _ _Yes		Psychiatric care Kidney or bladder disease	
Yes N	•			Yes		VD, herpes	
 _YesN		e, murmurs, prolapse,		Yes		HIV positive, AIDS, ARC	
		ver, prosthetic heart valve			_No	Hepatitis or liver disease	
_YesN				Yes		Pregnant: month	
_YesN	No High blood p	ressure		Yes _	_No	Birth Control Pills	
_YesN	No Tobacco/alc	ohol		Yes	_No	Osteoporosis?	
_YesN	No Recreational	drugs			_No	Taking bisphosphonates?	
ist any and	all ALLERGIES: _			Yes	_No	Allergic to metals or latex?	
ist any and	all DRUGS/MEDIO	CATIONS you are taking: _					
-		,					
	· ·						
Date:	Exceptions:	nistort dated		_and conii	Pa	nat it states past and present conditions. atient's Signature	
					□ Nc	one	
					No	one	
					No	one	
						one	
						one	
						one	
						one	
						one	
					」 Nc	one	