

ACQUAINTANCE INFORMATION

Date _____

Patient Name _____

Preferred Name _____ Spouse's Name _____

Address _____

Birthdate _____ Social Security # _____

Home Number _____ Work Number _____ Cell Number _____

Email Address _____

How did you learn about our office? _____ Dentist _____

Employer _____ Employer Address _____

Insured's Name _____ Insured's Soc. Sec. # _____

Insured's Birthdate _____ Relationship to Patient _____

Insured's Employer _____ Occupation _____

Insured's Work Number _____ Insurance Company _____

Group No. _____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? yes _____ no _____ if yes: _____

Name of nearest relative not living with you _____ Phone _____

Complete Address _____

Whom may we notify in case of an emergency?

Name _____ Phone _____ Relationship to you _____

I give consent for the office of Dr. Kenneth R. Levine, to obtain and to release any and all information pertaining to my medical history, insurance or billing questions.

(OVER)

Signature _____

MEDICAL HISTORY

Name of Physician _____ Last Appt. _____ Phone _____

Are you pregnant? Yes No If yes, anticipated delivery date _____

Do you wear contact lenses? Yes No

Circle a definite answer for each question:

Yes No Any change in your health in the past two years?

Yes No Are you currently under the care of a physician?

If yes, describe your treatment _____

Yes No Have you had any medical treatment or physician visit of any kind in the last two years?

If yes, describe _____

Yes No Have you ever had any surgical operation of any kind?

If yes, describe _____

Yes No Were you transfused at that time?

Yes No Have you been advised by a physician of the need for any surgery or treatment? for what? _____

Do you have, or have you ever been treated for any of the following?

Yes No Allergy	Yes No Mental disorders	Yes No Heart Problems
Yes No Arthritis	Yes No AIDS or HIV	Yes No Heart Murmur
Yes No Chronic Sinusitis	Yes No Tuberculosis	Yes No Mitral Valve Prolapse
Yes No Glaucoma	Yes No Diabetes	Yes No Valve Replacement
Yes No Thyroid Condition	Yes No Epilepsy, Seizures	Yes No Low Blood Pressure
Yes No Anemia, Sickle Cell Disease	Yes No Prolonged Bleeding	Yes No High Blood Pressure
Yes No Fainting	Yes No GI Problems	Yes No Pacemaker Type
Yes No Radiation/Chemical Therapy	Yes No Kidney Disorder	Yes No Shortness of Breath
Yes No Enzyme Deficiency	Yes No Hepatitis	Yes No Rheumatic Fever
Yes No Asthma	Yes No Ulcers	Yes No Hip or Joint Replacement
Yes No Chemical / Alcohol Dependency	Yes No Anorexia, Bulimia	Yes No Venereal Disease/Herpes II

Yes No Have you ever had an allergic reaction or been told not to take any medication?

if yes, describe _____

Yes No Are you currently taking any prescription drugs of any kind

(ex: Birth Control, Hormone, Diet)? If Yes, What? _____

Yes No Are you currently taking any non-prescription drugs? _____

Yes No Do you use any tobacco products? Daily intake _____

I CERTIFY THE ABOVE TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE _____ DATE _____

(OVER)

History of Bisphosphonates? Oral: Fosqmax, Actonel, Boniva. IV: Zometa, Aredia

When and for how long? _____