



206 Airport Road Kinston, NC 28504 PH: (252) 522-1777

PATIENT INFORMATION

Name	Birthdate// Age
Social Security Number	
Home Phone Number () Cell Pho	one Number ()
Email Address	<u> </u>
Which Phone Number would you like for us to use to	confirm appointments? (Circle) Home Work Cell
Street Address (required)	
CityState	_Zip
Circle Appropriate: Minor Single Married Di	vorced Widowed Separated
Patient's Employer	Work Phone ()
Spouse's Name	Employer
Work Phone (Cell Phone (Email
Person to Contact In the Case of an Emergency	Phone ()
Whom May We Thank For Referring You	
IF PATIENT IS A MINOR, PROVIDE INFO	RMATION
<u>IF PATIENT IS A MINOR, PROVIDE INFO</u>	RMATION
Name of Person Responsible for This Account	
Name of Person Responsible for This Account	
Name of Person Responsible for This Account	Relationship
Name of Person Responsible for This Account	Relationship
Name of Person Responsible for This Account Is the Responsible Party Currently a Patient in our Off Address City Social Security Number Home Phone	Relationship
Name of Person Responsible for This Account Is the Responsible Party Currently a Patient in our Off Address City Social Security Number Home Phone Cell Phone () Email	Relationship
Name of Person Responsible for This Account Is the Responsible Party Currently a Patient in our Off Address City Social Security Number Home Phone Cell Phone () Email	
Name of Person Responsible for This Account Is the Responsible Party Currently a Patient in our Off Address City Social Security Number Home Phone Cell Phone () Email	
Name of Person Responsible for This Account	
Name of Person Responsible for This Account	
Name of Person Responsible for This Account	
Name of Person Responsible for This Account	
Name of Person Responsible for This Account	

1. 2. 3. 4. For the following questions circle Yes or No. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your responses. Our team may ask additional questions concerning your health. Anemia or Blood Disorder? No Yes Hepatitis, Any Form No Yes Arthritis, Rheumatism or other inflammatory No Yes Joint Replacement? When placed? Asthma No Yes Liver Disease No Yes Abnormal Bleeding from a cut? No Yes Liver Disease (including No Yes Diabetes) Cancer or Tumor? No Yes Psychosis No Yes Emphysema or other Respiratory/Lung No Yes Previous Biopsies No Yes Emphysema or other Respiratory/Lung No Yes Previous Biopsies No Yes Emphysema or other Respiratory/Lung No Yes Radiation or Chemotherapy Treatment Yes Rheumatic Fever No Yes Glaucoma No Yes Rheumatic Fever No Yes Canceromal Heart or Previous Bacterial No Yes Unintentional Weight No Yes Congenital Heart Disease No Yes Loss/Gain Loss/Gain Loss/Gain Heart Disease No Yes Heart Disease, Heart Attack, Heart Surgery No Yes Recurrent Illnesses No Yes Heart Stent? When placed? Are you taking any of these medications? Pre-medication before dental No Yes Cardizem® (diltiazem) or Calan, Isoptin® No Yes Barbiturates (any) No Yes Diltucan® (fluconazole) or Sporonox® No Yes Cardizem® (diltiazem) or Calan, Isoptin® No Yes Barbiturates (any) No Yes Biaxin® (clarithromycin) No Yes Diltucan® (fluconazole) or Sporonox® No Yes Serzone® (nefazodone) No Yes Serzones® (nefazodone) No Yes Serzones® (nefazodone) No Yes Diltucan® (fluconazole) or Sporonox® No Yes Diltucan® (fluconazole) or Sporonox® No Yes Serzones® (nefazodone) No Yes Serzones® (nefazodone) No Yes Diltucan® (fluconazole) or	Please list all the names and phone	number	rs of	the pl	hvsiciar	ns who are currently providing you	care:	
3. 4. For the following questions circle Yes or No. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your responses. Our team may ask additional questions concerning your health. Anemia or Blood Disorder? No Yes Hepatitis, Any Form No Yes Arthritis, Rheumatism or other inflammatory No Yes Hepatitis, Any Form No Yes Arthritis, Rheumatism or other inflammatory No Yes Joint Replacement? When placed? Asthma No Yes Kidney Disease No Yes Asthma No Yes Liver Disease (including No Yes Jaundice) No Yes Sove/Enlarged Lymph Nodes No Yes Jaundice) No Yes Sove/Enlarged Lymph Nodes No Yes Psychosis No Yes Previous Biopsies No Yes Psychosis No Yes Previous Biopsies No Yes Previous Bacterial No Yes Sove-Healing Mouth Sores No Yes Abnormal Heart or Previous Bacterial No Yes Sove-Healing Mouth Sores No Yes Congenital Heart or Previous Bacterial No Yes Loss/Gain No Yes Previous Bacterial No Yes Previous Previous	_			F				
4. For the following questions circle Yes or No. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your responses. Our team may ask additional questions concerning your health. Anemia or Blood Disorder? No Yes Hepatitis, Any Form No Yes Arthritis, Rheumatism or other inflammatory No Yes Hospitis, Any Form No Yes Arthritis, Rheumatism or other inflammatory No Yes Hospitis, Any Form No Yes Ashma No Yes Kidney Disease No Yes Ashma No Yes Kidney Disease (including Janudice) Cancer or Tumor? No Yes Sorre/Enlarged Lymph Nodes No Yes Emphysema or other Respiratory/Lung No Yes Previous Biopsies No Yes Emphysema or other Respiratory/Lung No Yes Radiation or Chemotherapy Treatment Previous Bacterial No Yes Resulting or Dizzy Spells No Yes Reductional Heart or Previous Bacterial No Yes Slow-Healing Mouth Sores No Yes Glaucoma No Yes Slow-Healing Mouth Sores No Yes Endocarditis No Yes Unintentional Weight No Yes Reart Transplant No Yes Unintentional Weight No Yes Heart Disease No Yes Heart Disease No Yes Heart Disease No Yes Heart Disease No Yes Heart Stent? When placed? Are you taking any of these medications? Pre-medication before dental No Yes Cardizen® (dilitazem) or Calan, Isoptin® No Yes Treatment? Antacids? No Yes Barbiurates (any) No Yes Difflucan® (filticomazole) or Sporonox® No Yes Antacids? No Yes Barbiurates (any) No Yes Biaxin® (clarithromycin) No Yes Antacids No Yes Influence of Prepared the William Sponson No Yes Difflucan® (filticomazole) or Sporonox® No Yes Antacids No Yes No Yes Biaxin® (clarithromycin) No Yes No Yes Influence and Place of Prepared the William Sponson No Yes Influence of Prepared the William Sponson No Yes Influence of Prepared Spons	2.							
For the following questions circle Yes or No. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your responses. Our team may ask additional questions concerning your health. Anemia or Blood Disorder? No Yes Hepatitis, Any Form No Yes Joint Replacement? When No Yes disease? Asthma No Yes Stidney Disease (including Janudice) Asthma No Yes Liver Disease (including Janudice) Cancer or Tumor? No Yes Sore/Enlarged Lymph Nodes No Yes Emphysema or other Respiratory/Lung No Yes Psychosis No Yes Emphysema or other Respiratory/Lung No Yes Radiation or Chemotherapy No Yes Inlensess Epilepsy No Yes Radiation or Chemotherapy No Yes Radiation or Chemotherapy No Yes Sore/Enlarged Lymph Nodes No Yes Emphysema or other Respiratory/Lung No Yes Redurantic Fever No Yes Inlensess Epilepsy No Yes Radiation or Chemotherapy No Yes Radiation or Chemotherapy No Yes Sore/Enlarged Lymph Nodes No Yes Individual Nodes No Yes Individual Nodes No Yes Redurantic Fever No Yes Redurantic Fever No Yes Abnormal Heart or Previous Bacterial No Yes Unintentional Weight No Yes Congenital Heart Or Heart Transplant No Yes H.I.V. Infection/AIDS or ARC No Yes Heart Disease, Heart Attack, Heart Surgery No Yes Other Conditions No Yes Heart Disease No Yes No Yes No Yes Recurrent Illnesses No Yes Heart Disease No Yes No Yes Recurrent Illnesses No Yes Heart Disease, No Yes No Yes Cardizen® (diltiazem) or Calan, Isoptin® No Yes Indiation or Tegretol® No Yes Sorzone® (nefazodone) No Yes No Yes Districtional No Yes Sorzone® (nefazodone) No Yes No Yes Districtional No Yes Sorzone® (fluetonazole) or Sporonox® No Yes Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, No Yes Districtional No Yes Districtions No Yes No Yes Districtions No Yes No Yes Districtions No Yes Districtions No Yes No Yes Districtions No Yes Districtions No Yes Districtions No								
confidential. Please note that during your initial visit you will be asked some questions about your responses. Our team may ask additional questions concerning your health. Anemia or Blood Disorder? No Yes Hepatitis, Any Form No Yes Arthritis, Rheumatism or other inflammatory No Yes Joint Replacement? When placed? Asthma No Yes Kidney Disease No Yes Abnormal Bleeding from a cut? No Yes Liver Disease (including No Yes Diabetes No Yes Diabetes No Yes Psychosis No Yes Diabetes No Yes Psychosis No Yes Diabetes No Yes Psychosis No Yes Psychosis No Yes Illnesses Epilepsy No Yes Radiation or Chemotherapy No Yes Private Previous Biopsies No Yes Illnesses Epilepsy No Yes Redurantic Fever No Yes Abnormal Heart or Previous Bacterial No Yes Unintentional Weight No Yes Congenital Heart Disease No Yes Unintentional Weight Loss/Gain Heart Disease, Heart Attack, Heart Surgery No Yes Other Conditions No Yes Heart Stent? When placed? Are you taking any of these medications? Pre-medication before dental No Yes Serzone® (including No Yes Recurrent Illnesses No Yes Cardizem® (illitazem) or Calan, Isoptin® No Yes Dilantin® or Tegretol® No Yes Dilantin® or Tegretol® No Yes Barbiturates (any) No Yes Barbiturates (inconazole) or Sporonox® No Yes Barbiturates (any) No Yes Barbiturates (any) No Yes Barbiturates (any) No Yes Barbiturates (any) Pres Medications you are taking, and for what purpose: 1. 2. 3. 4. 5. Please list any dietary or herbal supplements you are taking, and for what purpose: 1. 2. 4. 5.			-					
No No No No No No No No								
Anemia or Blood Disorder?							your	
Arthritis, Rheumatism or other inflammatory disease? No Yes Kidney Disease No Yes Asthma No Yes Kidney Disease No Yes Asthma No Yes Kidney Disease No Yes Abnormal Bleeding from a cut? No Yes Liver Disease (including Jaundice) Cancer or Tumor? No Yes Sore/Enlarged Lymph Nodes No Yes Diabetes No Yes Psychosis No Yes Emphysema or other Respiratory/Lung No Yes Previous Biopsies No Yes Emphysema or other Respiratory/Lung No Yes Previous Biopsies No Yes Emphysema or other Respiratory/Lung No Yes Radiation or Chemotherapy No Yes Emphysema Or Dizzy Spells No Yes Radiation or Chemotherapy Treatment Previous Bacterial No Yes Slow-Healing Mouth Sores No Yes Glaucoma No Yes Slow-Healing Mouth Sores No Yes Abnormal Heart or Previous Bacterial No Yes Unintentional Weight No Yes Congenital Heart Disease, Heart Attack, Heart Surgery No Yes Venereal Disease No Yes Heart Disease, Heart Attack, Heart Surgery No Yes Other Conditions No Yes Heart Stent? When placed? No Yes Recurrent Illnesses No Yes Recurrent Illnesses No Yes Intentional Defore dental No Yes Recurrent Illnesses No Yes Cardizem® (diltiazem) or Calan, Isoptin® No Yes Dilantin® or Tegretol® No Yes Serzone® (diltiazem) or Calan, Isoptin® No Yes Dilantin® or Tegretol® No Yes Diluncan® (Rucanzole)? St. John's Wort or Kava-Kava? No Yes Barbiturates (any) No Yes Diluncan® (Rucanzole) or Sporonox® No Yes And Boniva®)? If so, when did the treatment begin? When did the treatment end? Please list any medications you are currently taking and dosages: 1. 2. 2. 3. 4. 5. 6. Please list any dietary or herbal supplements you are taking, and for what purpose: 1. 2. 4. 5.		ionai q	uesi				No	Yes
Asthma		mmato)TV					
Asthma Abnormal Bleeding from a cut? No Yes Abnormal Bleeding from a cut? No Yes Abnormal Bleeding from a cut? No Yes Liver Disease (including Janualice) No Yes Diabetes No No Yes Psychosis No Yes Emphysema or other Respiratory/Lung Illnesses Epillepsy No Yes Previous Biopsies No Yes Previous Biopsies No Yes Previous Biopsies No Yes Banting or Dizzy Spells No No Yes Banting or Dizzy Spells No No Yes Slow-Healing Mouth Sores No Yes Abnormal Heart or Previous Bacterial Endocarditis No No Yes Slow-Healing Mouth Sores No Yes Unintentional Weight Loss/Gain No Yes Hart Valve (artificial) or Heart Transplant No No Yes Heart Disease No Yes When placed? No Yes Tragamet® (cimetidine) or Prilosec® (omeprazole)? Antacids? No Yes Cardizem® (dilitiazem) or Calan, Isoptin® No Yes Bribturates (any) No			110	100		1.0		
Cancer or Tumor? No Yes Sore/Enlarged Lymph Nodes No Yes Diabetes No Yes Psychosis No Yes Emphysema or other Respiratory/Lung No Yes Previous Biopsies Epilepsy No Yes Radiation or Chemotherapy Treatment Treatment No Yes Psychosis Epilepsy No Yes Radiation or Chemotherapy Treatment Previous Biopsies Epilepsy No Yes Radiation or Chemotherapy Treatment Previous Biopsies Epilepsy No Yes Radiation or Chemotherapy No Yes Previous Biopsies Epilepsy No Yes Radiation or Chemotherapy No Yes Diabeted No Yes Slow-Healing Mouth Sores No Yes Unintentional Weight No Yes Endocarditis Heart or Previous Bacterial No Yes Unintentional Weight No Yes Congenital Heart Disease No Yes Venereal Disease No Yes Heart Disease, Heart Attack, Heart Surgery No Yes Venereal Disease No Yes Heart Stent? When placed? No Yes Recurrent Illnesses No Yes Are you taking any of these medications? Pre-medication before dental No Yes Cardizem® (diltiazem) or Calan, Isoptin® No Yes Treatment? Antacids? No Yes Serzone® (nefazodone) No Yes Barbiturates (any) No Yes Serzone® (nefazodone) No Yes Barbiturates (any) No Yes Biaxin® (clarithromycin) No Yes Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, No Yes Have you teen treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, No Yes Instant Boniva®)? If so, when did the treatment begin? Have you ever taken any prescription drugs such as fen-phen for weight loss? No Yes Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes Previous Biospies No Yes No Ye				No	Yes		No	Yes
Cancer or Tumor? No Yes Sore/Enlarged Lymph Nodes No Yes	Abnormal Bleeding from a cut?			No	Yes	Liver Disease (including	No	Yes
Diabetes No Yes Psychosis No Yes Emphysema or other Respiratory/Lung No Yes Previous Biopsies No Yes Previous Previous Biopsies No Yes Previous Biopsies No Yes Previous Previous No Previous Previous								
Emphysema or other Respiratory/Lung Illnesses Epilepsy No Yes Radiation or Chemotherapy Treatment Fainting or Dizzy Spells No Yes Rheumatic Fever Roboth Slaucoma No Yes Slow-Healing Mouth Sores No Yes Radiation or Chemotherapy Treatment No Yes Rheumatic Fever No Yes Radiation or Chemotherapy Treatment No Yes Rheumatic Fever No Yes Other Conditions No Yes Recurrent Illnesses No Yes Rheumatic Fever No Yes Rh	Cancer or Tumor?			No	Yes			
Illnesses No Yes Radiation or Chemotherapy Treatment Treatment Treatment Treatment No Yes Rheumatic Fever No Yes Glaucoma No Yes Slow-Healing Mouth Sores No Yes Sex S	Diabetes			No	Yes		No	
Epilepsy No Yes Radiation or Chemotherapy Treatment No Yes Fainting or Dizzy Spells No Yes Rheumatic Fever No Yes Glaucoma No Yes Slow-Healing Mouth Sores No Yes Abnormal Heart or Previous Bacterial No Yes Unintentional Weight No Yes Endocarditis No Yes Unintentional Meight No Yes Endocarditis No Ye	<u> </u>	ıng		No	Yes	Previous Biopsies	No	Yes
Fainting or Dizzy Spells No Yes Rheumatic Fever No Yes Glaucoma No Yes Slow-Healing Mouth Sores No Yes Abnormal Heart or Previous Bacterial No Yes Unintentional Weight No Yes Endocarditis Heart Valve (artificial) or Heart Transplant No Yes H.I.V. Infection/AIDS or ARC No Yes Congenital Heart Disease No Yes Heart Disease No Yes Heart Disease No Yes Heart Disease, Heart Attack, Heart Surgery No Yes Other Conditions No Yes Heart Stent? When placed? Are you taking any of these medications? Pre-medication before dental No Yes Cardizem® (cimetidine) or Prilosec® No Yes treatment? Antacids? No Yes Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)? Dilantin® or Tegretol® No Yes Diflucan® (fluconazole) or Sporonox® No Yes Gitraconazole) St. John's Wort or Kava-Kava? No Yes Biaxim® (clarithromycin) No Yes and Boniva®)? If so, when did the treatment end? Have you ever taken any prescription drugs such as fen-phen for weight loss? No Yes Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes Do you dietary or herbal supplements you are taking, and for what purpose: 1. 2. 3. 6. Please list any dietary or herbal supplements you are taking, and for what purpose: 1. 2. 3. 4. 2. 3. 4. 3. 4. 4. 5.								
Fainting or Dizzy Spells No Yes Rheumatic Fever No Yes	Epilepsy			No	Yes		No	Yes
Solution	Fainting or Dizzy Spells			No	Yes	Rheumatic Fever	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis Heart Valve (artificial) or Heart Transplant No Yes No Yes No Yes No Yes H.I.V. Infection/AIDS or ARC No Yes Congenital Heart Disease No Yes Heart Disease, Heart Attack, Heart Surgery No Yes Heart Disease, Heart Attack, Heart Surgery No Yes No Yes Other Conditions No Yes Are you taking any of these medications? Pre-medication before dental No Yes Tagamet® (cimetidine) or Prilosec® No Yes Aratacids? No Yes Cardizem® (diltiazem) or Calan, Isoptin® No Yes Barbiturates (any) No Yes St. John's Wort or Kava-Kava? No Yes Biaxin® (clarithromycin) No Yes And Boniva®)? If so, when did the treatment begin? Have you ever taken any prescription drugs such as fen-phen for weight loss? Please list any medications you are currently taking and dosages: 1. 2. 3. 4. 5. Please list any dietary or herbal supplements you are taking, and for what purpose: 1. 2. 3. 4. 5. Please list any dietary or herbal supplements you are taking, and for what purpose: 1. 2. 3. 4. 5. Please list any dietary or herbal supplements you are taking, and for what purpose: 1. 2. 3. 4. 5. Please list any dietary or herbal supplements you are taking, and for what purpose: 1. 2. 3. 4. 5. 4. 5. Please list any dietary or herbal supplements you are taking, and for what purpose: 1. 2. 3. 4. 5. Please list any dietary or herbal supplements you are taking, and for what purpose: 1. 2. 3. 4. 5. Please list any dietary or herbal supplements you are taking, and for what purpose: 1. 2. 3. 4. 5. Please list any dietary or herbal supplements you are taking, and for what purpose: 1. 2. 3. 4. 5. 5. 6. Please list any dietary or herbal supplements you are taking, and for what purpose: 1. 2. 3. 4. 5. 6.						Slow-Healing Mouth Sores	No	Yes
Heart Valve (artificial) or Heart Transplant No Yes H.I.V. Infection/AIDS or ARC No Yes		ial					No	Yes
No Yes Venereal Disease No Yes								
No Yes Venereal Disease No Yes		nsplan	t	No	Yes		No	Yes
Heart Disease, Heart Attack, Heart Surgery Heart Stent? When placed? No Yes Recurrent Illnesses No Yes Are you taking any of these medications? Pre-medication before dental No Yes (cimetidine) or Prilosec® No Yes Are you taking any of these medications? Pre-medication before dental No Yes Tagamet® (cimetidine) or Prilosec® No Yes treatment? Antacids? No Yes Cardizem® (diltiazem) or Calan, Isoptin® No Yes [Verapamil)? Dilantin® or Tegretol® No Yes Serzone® (nefazodone) No Yes Barbiturates (any) No Yes Diffucan® (fluconazole) or Sporonox® No Yes [itraconazole) St. John's Wort or Kava-Kava? No Yes Biaxin® (clarithromycin) No Yes Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, and Boniva®)? If so, when did the treatment begin? When did the treatment end? Have you ever taken any prescription drugs such as fen-phen for weight loss? Please list any medications you are currently taking and dosages: 1.					+		No	Yes
Heart Stent? When placed? No Yes Recurrent Illnesses No Yes Are you taking any of these medications? Pre-medication before dental No Yes (omeprazole)? Antacids? No Yes Cardizem® (diltiazem) or Calan, Isoptin® No Yes (Verapamil)? Dilantin® or Tegretol® No Yes Serzone® (nefazodone) No Yes Barbiturates (any) No Yes Diffucan® (fluconazole) or Sporonox® No Yes (itraconazole) St. John's Wort or Kava-Kava? No Yes Biaxin® (clarithromycin) No Yes Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, and Boniva®)? If so, when did the treatment begin? When did the treatment end? Have you ever taken any prescription drugs such as fen-phen for weight loss? No Yes Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes Please list any medications you are currently taking and dosages: 1. 2. 3. 4. 5. 6. Please list any dietary or herbal supplements you are taking, and for what purpose: 1. 2. 4. 5. 4. 6.								
Are you taking any of these medications? Pre-medication before dental treatment? Antacids? No Yes Cardizem® (diltiazem) or Calan, Isoptin® No Yes (Verapamil)? Dilantin® or Tegretol® No Yes Serzone® (nefazodone) No Yes Barbiturates (any) No Yes Diflucan® (fluconazole) or Sporonox® No Yes (itraconazole) St. John's Wort or Kava-Kava? No Yes Biaxin® (clarithromycin) No Yes Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, and Boniva®)? If so, when did the treatment begin? When did the treatment end? Have you ever taken any prescription drugs such as fen-phen for weight loss? No Yes Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes Please list any medications you are currently taking and dosages: 1. 2. 3. 4. 5. 6. Please list any dietary or herbal supplements you are taking, and for what purpose: 1. 2. 4. 5. 4. 6.				+		+		
Pre-medication before dental treatment? Antacids? No Yes Cardizem® (diltiazem) or Calan, Isoptin® No Yes (Verapamil)? Dilantin® or Tegretol® No Yes Serzone® (nefazodone) No Yes Barbiturates (any) No Yes Difflucan® (fluconazole) or Sporonox® (itraconazole) St. John's Wort or Kava-Kava? No Yes Biaxin® (clarithromycin) No Yes Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, and Boniva®)? If so, when did the treatment begin? When did the treatment end? Have you ever taken any prescription drugs such as fen-phen for weight loss? No Yes Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes Please list any medications you are currently taking and dosages: 1. 2. 4. 5. 6. Please list any dietary or herbal supplements you are taking, and for what purpose: 1. 2. 4. 5. 4. 5. 4. 5. 4. 5. 6.	Hour Stone: Whom piacou.			1	1 200		1	
treatment? Antacids? No Yes Cardizem® (diltiazem) or Calan, Isoptin® No Yes Dilantin® or Tegretol® No Yes Serzone® (nefazodone) No Yes Diflucan® (fluconazole) or Sporonox® No Yes Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, and Boniva®)? If so, when did the treatment begin? Have you ever taken any prescription drugs such as fen-phen for weight loss? No Yes Do you consume grapefruit juice, grapefruits or grapefruit extract? Please list any medications you are currently taking and dosages: 1. 2. 3. 4. 5. 6. Please list any dietary or herbal supplements you are taking, and for what purpose: 1. 2. 4. 4. 4.	Are you taking any of these medica	tions?					_	
Antacids? No Yes Cardizem® (diltiazem) or Calan, Isoptin® No Yes (Verapamil)? Dilantin® or Tegretol® No Yes Serzone® (nefazodone) No Yes Barbiturates (any) No Yes Diflucan® (fluconazole) or Sporonox® No Yes (itraconazole) St. John's Wort or Kava-Kava? No Yes Biaxin® (clarithromycin) No Yes Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, and Boniva®)? If so, when did the treatment begin? When did the treatment end? Have you ever taken any prescription drugs such as fen-phen for weight loss? No Yes Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes Please list any medications you are currently taking and dosages: 1. 2. 3. 4. 5. 6. Please list any dietary or herbal supplements you are taking, and for what purpose: 1. 2. 4. 4. 4.	Pre-medication before dental	No	Ye	s T	agamet	(cimetidine) or Prilosec®	No	Yes
Dilantin® or Tegretol® No Yes Serzone® (nefazodone) No Yes Barbiturates (any) No Yes Diflucan® (fluconazole) or Sporonox® No Yes St. John's Wort or Kava-Kava? No Yes Biaxin® (clarithromycin) No Yes Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, and Boniva®)? If so, when did the treatment begin? When did the treatment end? Have you ever taken any prescription drugs such as fen-phen for weight loss? No Yes Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes Please list any medications you are currently taking and dosages: 1	treatment?			(0	mepraz	ole)?		
Dilantin® or Tegretol® No Yes Serzon® (nefazodone) No Yes Barbiturates (any) No Yes Diflucan® (fluconazole) or Sporonox® No Yes St. John's Wort or Kava-Kava? No Yes Biaxin® (clarithromycin) No Yes Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, and Boniva®)? If so, when did the treatment begin? When did the treatment end? Have you ever taken any prescription drugs such as fen-phen for weight loss? No Yes Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes Please list any medications you are currently taking and dosages: 1.	Antacids?	No	Ye				No	Yes
Barbiturates (any) No Yes Diflucan® (fluconazole) or Sporonox® (itraconazole) St. John's Wort or Kava-Kava? No Yes Biaxin® (clarithromycin) Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, and Boniva®)? If so, when did the treatment begin? Have you ever taken any prescription drugs such as fen-phen for weight loss? No Yes Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes Please list any medications you are currently taking and dosages: 1. 2. 4. 5. 6. Please list any dietary or herbal supplements you are taking, and for what purpose: 1. 2. 4. 3. 4. 4. 5. 4. 6.	······							
St. John's Wort or Kava-Kava? No Yes Biaxin® (clarithromycin) Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, and Boniva®)? If so, when did the treatment begin? Have you ever taken any prescription drugs such as fen-phen for weight loss? No Yes Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes Please list any medications you are currently taking and dosages: 1				s S	erzone®	(nefazodone)		
St. John's Wort or Kava-Kava? No Yes Biaxin® (clarithromycin) Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, and Boniva®)? If so, when did the treatment begin? When did the treatment end? Have you ever taken any prescription drugs such as fen-phen for weight loss? No Yes Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes Please list any medications you are currently taking and dosages: 1.	Barbiturates (any)	No	Ye			No	Yes	
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, and Boniva®)? If so, when did the treatment begin? When did the treatment end? Have you ever taken any prescription drugs such as fen-phen for weight loss? No Yes Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes Please list any medications you are currently taking and dosages: 1.				NT-	Voz			
and Boniva®)? If so, when did the treatment begin? When did the treatment end? Have you ever taken any prescription drugs such as fen-phen for weight loss? No Yes Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes Please list any medications you are currently taking and dosages: 1. 2. 4. 5. 6. Please list any dietary or herbal supplements you are taking, and for what purpose: 1. 2. 4. 5. 4. 6.	St. John's Wort or Kava-Kava? No Yes Biaxin* (clarithromycin)			_				
treatment end? Have you ever taken any prescription drugs such as fen-phen for weight loss? No Yes Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes Please list any medications you are currently taking and dosages: 1. 2. 4. 5. 6. Please list any dietary or herbal supplements you are taking, and for what purpose: 1. 2. 4. 2. 4. 3. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4.	Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, No Yes							
Have you ever taken any prescription drugs such as fen-phen for weight loss? Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes Please list any medications you are currently taking and dosages: 1.		treatm	ent c	egin?		when did the		
Please list any medications you are currently taking and dosages: 1. 2. 4. 5. 6. Please list any dietary or herbal supplements you are taking, and for what purpose: 1. 2. 4. 5. 4. 5. 4. 4. 5. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4. 4.	Here you ever telep only procesinti	on dmi	~~ ~~	oh oc	fon nhe	on for weight loss?	No	Ves
Please list any medications you are currently taking and dosages: 1.								
1.	Do you consume graperruit juice, graperruits or graperruit extract?				1 140	1 100		
1	Dlegge list any medications you are	curren	tlv t	akino	and do	sages.		
3	· · · · · · · · · · · · · · · · · · ·		-	_		_		
5 6 6. Please list any dietary or herbal supplements you are taking, and for what purpose: 1 2 4 4.	3.							
Please list any dietary or herbal supplements you are taking, and for what purpose: 1								
1 2								-
3 4		_				_		
5	5. 5.					 6.		

Women:	Are you pregna	ant?			No	Yes	S	
	If no, are you planning a pregnancy in the near future?				Yes			
	Are you a nursing mother?					Ye		
	Are you taking birth control pills?				Ye	3		
Abnorma	al Blood Pressur	e? (Please c	ircle)		No	Yes	S	
	Have you ever r	eceived a di	agnosis of "high blood	pressure"?				
	What is your no	rmal blood	pressure?/	Today:/	_			
A === =====								
Are you	allergic or have	you nad a re	eaction to:		37-	Yes		
b.	a. Local anesthetics							
							Yes Yes	
d.							Yes	
				•••••	No	Yes		
f.	Other (please sp	pecify)						
Do you ı	ise tobacco? If	yes, circle ty	pe: smoke chew Ho	ow much per day?	For	No	Yes	
how long								
	want to quit using					No	Yes	
Do you o	consume alcohol	? If yes, ap	proximately how many	alcoholic beverages per w	veek?	No	Yes	
Do you t	ise any mood alt	ering drugs	other than those previou	ısly listed?		No	Yes	
Weight	Moole nor	Dia	tam. Dantaiatiana	T 14				
weight	Meals per Day	Die	tary Restrictions	Food A	llergies			
	Duy							
Sugar in	your diet (circle	one): none	slight moderate	high				
		1,7	No.					
			8					
I undersi	and the above ir	nformation i	s necessary to provide n	ne with dental care in a se	afe and e	efficient		
manner.	I have answered	d all questio	ns to the best of my kno	wledge. Should further in	ıformati	on be ne	eded,	
informat	ion to you. I wil	lo ask the re	spective nealth care pro loctor of change in my h	ovider or agency, who ma	y releas	e such		
myorman	ion io you. 1 wii	i notify the t	locior of change in my i	ieaith ana meaicatíon.				
Patient (Print Name)		Patient Signatu	re D	ate			
	,		8	-				
DOCT	OR'S USE O	NLY						
Commen	its on patient into	erview conc	erning medical history:					
Significa	nt findings from	questionna	ire or oral interview:					
	Ş	1	a or oral miles (10).					
D	D							
Doctor (Print Name)		Doctor Signatur	re D	ate			

IN	SURANCE AUTHORIZATION
	I authorize my insurance company to pay the dentist all insurance benefits rendered. I authorize the use of this electronic signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.
	By checking the box, I consent the the listed above.
SE	RVICES AND FINANCIAL POLICY
	As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made
	Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
	In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.
	I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.
	By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Administration Form.
CA	ANCELLATION POLICY
<u> </u>	We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours in advance.
	Our doctors & hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show appointments, and those appointments not cancelled within 24 hours.
	BROKEN APPOINTMENT POLICY - after two broken appointments with less than 24 hrs notice, you will receive a warning letter; after three broken appointments with less than 24 hrs, you will be dismissed from the practice. This will be determined at our discretion.
	Thank you for being a valued patient and for your understanding and cooperation. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.
	By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Cancellation Policy.

Signature ______Date _____

ACKNOWLEDGEMENT OF PRIVACY POLICY Patient Name & Address: I have received a copy of the Notice of Privacy Practices for the above named practice or have the option to request one at any time. Signature: _____ Date: _____ For Office Use Only We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because: An emergency existed & a signature was not possible at the time. The individual refused to sign. A copy was mailed with a request for a signature by return mail. Unable to communicate with the patient for the following reason: □ Other:____ Prepared By _____ Signature: _____ Date:

THE PROPERTY OF THE PROPERTY O