ANACAPA ORAL SURGERY
DENTAL IMPLANT CENTER
MARWOOD STOUT, DDS

Welcome to our office. To better serve you, please provide the following information:

Mr. Mrs. Ms.	LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH

PATIENT ADDRESS	CITY	ZIP	EMAIL ADDRESS

HOME PHONE NUMBER	WORK PHONE NUMBER	CELLPHONE NUMBER	YOUR SOCIAL SECURITY NUMBER

NAME OF SPOUSE (OR PARENT OR GUARDIAN, IF PATIENT IS A MINOR)	PARENT SOCIAL SECURITY NUMBER	PARENT DATE OF BIRTH

PATIENT'S PLACE OF EMPLOYMENT	INSURANCE SUBSCRIBER PLACE OF EMPLOYMENT

PRIMARY DENTAL INSURANCE COMPANY	SUBSCRIBER'S NAME	SUBSCRIBER SOCIAL SECURITY NUMBER	DATE OF BIRTH

SECONDARY DENTAL INSURANCE COMPANY	SUBSCRIBER'S NAME	SUBSCRIBER SOCIAL SECURITY NUMBER	DATE OF BIRTH

YOUR GENERAL DENTIST / ORTHODONTIST	WHOM CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?	EMERGENCY CONTACT PERSON / PHONE

Please respond by circling either yes ("Y") or no ("N") if you have ever had any of the following:

Y N Obstructive Sleep Apnea
Y N Sinus Disease
Y N Eye or Ear Disease
Y N High Blood Pressure
Y N Irregular Heartbeat
Y N Heart Attack, year _____
Y N Heart Murmur
Y N Artificial or Repaired Valve
Y N Pacemaker
Y N Chest Pain
Y N Shortness of Breath
Y N Stroke
Y N Asthma
Y N Tuberculosis
Y N Hepatitis/ Liver Disease
Y N Gastric Reflux Disease

Y N Diabetes
Y N Ulcers/ Bowel Disease
Y N Kidney Disease
Y N Arthritis
Y N Artificial Joints, year _____
Y N Bleeding/ Clotting Disorders
Y N Cancer Radiation Treatment
Y N Cancer Chemotherapy
Y N Immune System Disease
Y N Anemia
Y N Thyroid/ Endocrine Disease
Y N +HIV, AIDS
Y N Seizures or Nerve Disease
Y N Clinical Depression
Y N Other Psychiatric Disease
Describe _____

Y N Clicking, Popping, Locking or Pain in the Jaw Joint
Y N Currently Pregnant
Y N Currently Breast Feeding
Y N Tobacco Use
Describe_____
Y N Alcohol _____ drinks/week
Y N Prior/current use of Zometa or Aredia for chemotherapy
Y N Prior/current use of Fosamax, Actonel, Boniva, or Reclast for osteoporosis
Y N Prior/current use of Phenfen diet pills
Y N Prior/current Drug Abuse
Describe _____

Please list any other serious illnesses or conditions and any prior surgeries or complications: _____

_____

_____

Please list all medical or serious food allergies:_____

Please list any medications you take routinely or have taken recently: _____

_____

Your Physician's name: _____ Your Height: _____ Your Weight: _____ Age_____

I consent to a physical and radiographic exam. If antibiotics are prescribed, I understand they may prevent the proper function of birth control medications. I have had opportunity to read the "Notice of Privacy Practices" and consent to the privacy policy of this office**. I understand I am solely responsible for all treatment costs**; however, I consent to assignment of insurance benefits to pay Anacapa Oral Surgery Dental Implant Center directly. I understand there are charges for failed appointments. If signing for a minor, I certify my signature alone is sufficient to consent to treatment and that I am solely responsible for all treatment costs incurred by the minor patient.

_____ _____ _____

Signature of Patient or Parent/Guardian: Date