RON MAMRICK DDS, PC
FAMILY & COSMETIC DENTISTRY

PATIENT INFORMATION AND HEALTH HISTORY

Patient Name _____
Last First MI

Preferred name: _____ Title: _____ (Mr/Ms/Mrs/etc) Gender: M F

Family Status: Married Single Child Other Birthdate: _____ MM/DD/YYYY

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____
Street City State Zip

Email Address: _____ Referred by: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Responsible Party Information (if other than Patient):

Name _____
Last First MI

Preferred name: _____ Title: _____ (Mr/Ms/Mrs/etc) Gender: M F

Family Status: Married Single Child Other Birthdate: _____ MM/DD/YYYY

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____
Street City State Zip

Dental Insurance Information *(if applicable)*

Primary Dental Insurance		**Secondary Dental Insurance**	
Insurance Carrier:		Insurance Carrier:	
Name of Insured:		Name of Insured:	
Insured's Date of Birth:		Insured's Date of Birth:	
Insured's SSN or ID#:		Insured's SSN or ID#:	
Group #:		Group #:	
Insured Employer's Name:		Insured Employer's Name:	

Health History Information

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions about your health. This information is to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Do you have any of the following diseases or problems?

Active Tuberculousis	☐ Yes ☐ No	Cough that produces blood	☐ Yes ☐ No
Persistent cough greater than a 3 week duration	☐ Yes ☐ No	Been exposed to anyone with tuberculousis	☐ Yes ☐ No

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Health History Information *(continued)* **Patient Name:** _____

Are you now under the care of a physician? ☐ Yes ☐ No Date of last medical exam: _____

Physician Name: _____ Phone Number: _____

Has there been any change in your general health within the past year? ☐ Yes ☐ No	Have you ever experienced of the following problems in your jaw? Clicking, pain (joint, ear, side of face), difficulty opening or closing, or difficulty in chewing? ☐ Yes ☐ No
Have you had a serious illness, operation or been hospitalized in the past 5 years? If so, what was the illness or problem? ☐ Yes ☐ No	Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ Yes ☐ No Date treatment began: _____
Are you taking, or have you taken any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramin) or phen-fen (fenfluramine-phentermine combination)? ☐ Yes ☐ No	Do you drink alcoholic beverages? ☐ Yes ☐ No If yes, how much did you drink in the last 24 hours? _ _____ How much do you typically drink in a week? _____
Are you taking or scheduled to begin taking any bisphosphonates for osteoporosis or Paget's disease? ☐ Yes ☐ No	Do you use controlled substances (drugs)? ☐ Yes ☐ No
Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Date: _____ ☐ Yes ☐ No If yes, have you had any complications? _____ _____	
Do you use tobacco (smoking, snuff, chew, bidis)? ☐ Yes ☐ No If so, how interested are you in stopping? _____ _____	

Please read carefully and check all that apply:

- ☐ Heart Murmer
- ☐ Mitral Valve Prolapse
- ☐ Artificial heart valves
- ☐ Rheumatic fever
- ☐ Cardiovascular Disease
- ☐ Angina
- ☐ Arteriosclerosis
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Damaged heart valves
- ☐ Heart attack
- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ Congenital heart defects
- ☐ Pacemaker
- ☐ Anemia
- ☐ Blood transfusion
  If yes, date: _____
- ☐ Hemophilia
- ☐ AIDS or HIV infection
- ☐ Arthritis
- ☐ Autoimmune disease
- ☐ Rheumatoid arthritis
- ☐ Systemic lupis erythematosus
- ☐ Asthma
- ☐ Emphysema
- ☐ Sinus trouble
- ☐ Tuberculosis
- ☐ Cancer/chemotherapy/ Radiation treatment
- ☐ Abnormal bleeding
- ☐ Chronic pain
- ☐ Diabeties Type I or II
- ☐ Eating disorder
- ☐ Malnutrition
- ☐ Gastrointestinal Disease
- ☐ G.E. Reflux/Persistent heartburn
- ☐ Ulcers
- ☐ Thyroid problems
- ☐ Stroke
- ☐ Glaucoma
- ☐ Hepatitis, jaundice or liver disease
- ☐ Rheumatic heart disease
- ☐ Epilepsy
- ☐ Fainting spells or seizures
- ☐ Neurological disorders
  If yes, specify: _____
- ☐ Kidney problems
- ☐ Night sweats
- ☐ Osteoporosis
- ☐ Persistent swollen glands in neck
- ☐ Severe headaches/ migraines
- ☐ Severe or rapid weight loss

Please list ALL medications you are currently Taking including vitamins, natural or herbal preparations and/or diet supplements:

_____
_____
_____
_____

Allergies: Are you allergic to or have you had a reaction to any of the following:

Penicillin or other antibiotics	☐ Yes ☐ No
Sulfa Drugs	☐ Yes ☐ No
Codeine or other narcotics	☐ Yes ☐ No
Metals	☐ Yes ☐ No
Latex (rubber)	☐ Yes ☐ No

Please tell us about any other medical conditions you may have, or therapy used which is not listed above:

_____
_____
_____
_____
_____

Please list any other allergies or adverse reactions to medication not listed above:

_____
_____
_____
_____
_____

Patient (or Responsible Party) Signature: _____ Date: _____

Dentist Notes:

_____
_____
_____