Drs. Peoples, Oghalai and Krutoy

Account #

Patient Information

First	Middle	Last	Suffix	Preferred Name

Address	City	State/Zip

Home Number	Cell Number	Work Number	Email Address
( )	( )	( )	

All telephone numbers provided by you may be subject to receiving telephone calls from an automated dialer using a pre-recorded voice message or live operator call. You give your consent to receive such phone calls, including any calls made to the provided cellular phone number.

Date of Birth	Social Security #	Age	Sex (Circle) M / F	Marital Status (Circle) S / M / D / W

Employer	Employer Address	Status (Circle) FT/PT/Retired/Unemp.

School Information (If Student)	School Address	Status (Circle) FT / PT

General Dentist	Referred By

PRIMARY DENTAL INSURANCE INFORMATION

Insurance Name & Address	Company/Employer

Insurance ID #	Insurance Group #

Insured Name	Relationship to Patient

Insured Address (☐ Same as above)

City / State / Zip

Insured DOB	Insured Social Security #

SECONDARY DENTAL INSURANCE INFORMATION

Insurance Name & Address	Company/Employer

Insurance ID #	Insurance Group #

Insured Name	Relationship to Patient

Insured Address (☐ Same as above)

City / State / Zip

Insured DOB	Insured Social Security #

PRIMARY MEDICAL INSURANCE INFORMATION

Insurance Name & Address	Company/Employer

Insurance ID #	Insurance Group #

Insured Name	Relationship to Patient

Insured Address (☐ Same as above)

City / State / Zip

Insured DOB	Insured Social Security #

SECONDARY MEDICAL INSURANCE INFORMATION

Insurance Name & Address	Company/Employer

Insurance ID #	Insurance Group #

Insured Name	Relationship to Patient

Insured Address (☐ Same as above)

City / State / Zip

Insured DOB	Insured Social Security #

Guarantor/Responsible Party

☐ SELF ☐ OTHER

Guarantor Name	Relationship to Patient	Date of Birth	Social Security #

Address (☐ Same as Above)	City/State/Zip	Phone (Home / Cell)

Guarantor/Responsible Party Signature **Date**

X

Emergency Contact Information

Emergency Contact Name	Relationship to Patient	Phone (Home / Cell)

STAFF INITIAL: _____

Drs. Peoples, Oghalai and Krutoy **Health History** **Patient ID#:**

Patient Name:		**Medical Doctor**	**Phone Number**
Height	**Weight**		

Medications (including Over the Counter / Herbal Supplements) ☐ **See Attached List**

Medication	Dose	Frequency	Medication	Dose	Frequency
1.			4		
2.			5.		
3.			6.		

Have You Had or Do You Currently Have	✓ Y	✓ N	Notes	Have You Had or Do You Currently Have	✓ Y	✓ N	Notes
Abnormal Heart Condition				History of Alcohol Abuse			
Asthma				History of Illegal Drug Use (including Marijuana)			
Bleeding Condition				Joint Replacement (i.e. Hip / Knee)			
Cardiac Pacemaker				Liver Disease			
Chemotherapy or IV Drug Treatment: (i.e. Aredia, Bonefos, Zometa) (for cancer: Breast, Prostate, or Multiple Myeloma				Osteoporosis Medicine: Actonel/Risedronate; Didronel Boniva/Ibandronic Acid Fosamax/Alendronate Prolia/Denosumab Reclast-Zometa/Zolendronic Acid Skelid/Tiludronate Disodium Fosamax/Alendronate			
COPD (Emphysema / Chronic Bronchitis)							
Damaged Heart Valves (i.e. Mitral Valve Proplase)				Radiation (other than x-rays/radiographs)			
Depression				Rheumatic Fever			
Diabetes				Sleep Apnea			
Epilepsy				Smoke / Use Tobacco			
Fainting or Black Out Spells							
Heart Attack / Surgery				INFECTIOUS DISEASES			
Heart Murmur				Hepatitis			
High Blood Pressure				HIV (Aids Virus)			
				Tuberculosis			

Allergies

Drug Allergies	Y	N	Notes	Drug Allergies	Y	N	Notes
Clindamycin				Oxycodone			
Codeine				Penicillin			
Erythromycin				Sulfa			
Hydrocodone				Egg, Soy, Peanuts			
Latex				Other			
Local Anesthetic				Other			
				Other			

Women Only

1-Are you currently taking Birth Control? ____ Y ____ N **2-**Are you Currently Pregnant? ___Y ___N (How Far Along? _____)
3-Are you currently nursing? ___Y ___N ***(Please note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician and/or gynecologist for assistance regarding additional methods of birth control.)***

Past Surgical History

1.	**4.**
2.	**5.**
3.	**6.**

Additional Comments / Information

By signing below, I acknowledge that I have read and answered the questions above to the best of my knowledge. I will not hold my surgeon or any other member of his staff responsible for errors or omissions that I have made in the completion of this form.

Patient (Guarantor Signature if under 18)	**Date**	**Staff Initials**