

# Gateway Dental

DATE \_\_\_\_\_

## Patient Information

Name \_\_\_\_\_ D.O.B. \_\_\_\_ - \_\_\_\_ - \_\_\_\_ SS# \_\_\_\_\_ DL# \_\_\_\_\_

Address \_\_\_\_\_

Email \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

## Insurance Information

Subscriber Name \_\_\_\_\_ D.O.B. \_\_\_\_ - \_\_\_\_ - \_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_ Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_ ID # \_\_\_\_\_ Phone # \_\_\_\_\_

## Patient Medical History

Do you have a history of?	Y N		Y N		Y N		Y N				
Rheumatic Fever			Ulcers/Stomach Problems			Are you pregnant?			Do you like your smile?		
Stroke			Allergies or Hives			HIV Positive/Aids			Pain in jaw		
Mitral Valve Prolapse			Anemia			Epilepsy or seizures			Excessive bleeding		
Diabetes			Aspirin Therapy			Sinus problems			Mouth sores/growths		
Pace Maker/Heart			Venereal Disease			Artificial Joints			Teeth grinding/clenching		
High/Low Blood Pressure			Drug Addiction Alcoholism			Cancer or Chemotherapy			Are your teeth sensitive to cold, hot, sweets or pressure		
Tuberculosis			Thyroid Disease			Lung Disease			Do your gums bleed		
Arthritis			Hepatitis A,B,C			Osteoporosis			Use of tobacco products		
Asthma/Breathing Problems			Liver/Kidney Disease			Heart Murmur or Heart Problems			Other		

Due to osteoporosis or cancer, are you taking or have taken Oral Bisphosphonates, e.g., FOSAMAX, ACTONEI, BONIVA, RECLAST or IV Bisphosphonates, e.g., ZOMETA, AREDIA, etc? If so, how long?

\_\_\_\_\_

List any medications you are allergic to \_\_\_\_\_

List any medications you are taking \_\_\_\_\_

Patient's signature \_\_\_\_\_

Doctor's signature \_\_\_\_\_