Pharmacy: _____

Joseph Arcuri II DDS

Oral & Maxillofacial Surgery

PATIENT INFORMATION/HEALTH HISTORY

DATE_____ **DATE OF BIRTH**_____ **AGE**_____

PATIENT NAME_____ **PARENT/GUARDIAN**_____

ADDRESS: Street_____Town_____State/Zip_____

DRIVERS LICENSE_____ ***E-MAIL**_____

SS#_____ SINGLE MARRIED DIVORCED WIDOWED

HOME PHONE_____ **CELL PHONE**_____ **WORK PHONE**_____

DENTAL INSURANCE YES/NO **DENTAL INSURANCE COMPANY**_____

EMERGENCY CONTACT [NAME/ADDRESS/PHONE]_____

FAMILY DENTIST_____ **MEDICAL DOCTOR**_____

MEDICAL HISTORY

Are you in good health Y/N **Are you taking any medications** Y/N

MEDICATION LIST_____

DRUG ALLERGIES_____

BEEN HOSPITALIZED/UNDER CARE OF PHYSICIAN IN PAST 5 YEARS? Y/N

_____

[circle if YES]

HEART DISEASE	EMPHYSEMA	ASTHMA	EPILEPSY
HEART MURMUR	ANEMIA	RHEUMATIC FEVER	HEART VALVE REPLACEMENT
ANGINA	DIABETES	JOINT REPLACEMENT	STROKE
HEART SURGERY	TOBACCO USE	ALCOHOL USE	HIGH BP
KIDNEY DIS	CANCER	RADIATION TREATMENT	CHEMOTHERAPY
THYROID DISEASE	LIVER DISEASE	HEPATITIS	ALLERGY MEDICATION
HEMOPHILIA	HIV+	INTELLECTUALLY CHALLENGED	ULCERS

HAVE YOU TAKEN FOSAMAX/ZOMETA/RECLAST/BONIVA/AREDIA/ACTONEL/PROLIA/XGEVA

YES/NO

WOMEN: Are you now or are you planning on becoming pregnant Y/N

Are you taking contraceptive medication? Y/N

Are you aware that some antibiotics cause contraceptive meds to be less affective? Y/N

TO THE BEST OF MY KNOWLEDGE, ALL OF MY RESPONSES ARE CORRECT AND TRUE. IF THERE ARE ANY CHANGES IN MY MEDICAL CONDITIONS I WILL NOTIFY DR. ARCURI. I UNDERSTAND I MAY NEED XRAYS TAKEN.

SIGNATURE:_____ DATE:_____