13905 E Noland Ct
Independence, MO 64055
(816) 461 - 2916

Please Print Clearly

Patient Full Name_______________________________________ Preferred Name________________________

Date of Birth_____/_____/______ Patient Social Security Number ______-_______-______

Drivers Lic: ________________________ State____________________

Parent or Guardian Name_____________________________________ Date of Birth______/______/_____

Mailing Address____

City____________________________________ State___________________ Zip___________

Home Number__________-__________-________ Cell ________-_______-______ Work______-_______-______

Emergency Contact Name____________________________ Number__________-_________-_________

Employer__________________________________ Employer Phone__________-__________-__________

Responsible Party

- Self
- Parent/Guardian Name___________________________________ Date of Birth_____/_____/_____
  Social Security ___________/_____________/__________

Dental Insurance Information

Primary Insurance Company____

Insurance Company Phone______________-____________-_____________

Group Number_______________________ Identification Number_____________________________

Policy Holder Name_____________________________________ Date of Birth_______/_______/_______

Secondary Insurance Company____

Insurance Company Phone______________-____________-_____________

Group Number_______________________ Identification Number_____________________________

Policy Holder Name_____________________________________ Date of Birth_______/_______/_______

Acknowledgement: I acknowledge the above information is true and correct to the best of my knowledge. I understand that failing to provide incorrect or false information could lead to dismissal from practice and legal ramifications.

Signature____ Date______/_______/_______

Health History Information

Are you currently under the care of a physician? Yes / No (please circle)

Have you ever been hospitalized or had a major operation? Yes / No (please circle) If Yes please explain:________________

Have you ever had a serious head or neck injury? Yes / No (please circle) If Yes please explain:______________________

Please list any and all drugs or medication you are currently taking:____

____

Have you ever taken Fosamax, Boniva Actonel or any other Bisphosponates? Yes / No (please circle)

Are you on a special diet?_ Yes / No (please circle) Do you use tobacco? Yes / No (please circle)

Do you use any controlled substance? Yes / No (please circle)

Women: Are you currently pregnant: Yes / No (please circle) If Yes: Due Date: _____/______/______

Are you nursing Y / N (please circle) Taking oral contraceptives? Y / N (please circle)

Do you have or have you had any of the following?**(MUST CIRCLE EACH ITEM)DO NOT LINE THROUGH**

AIDS/HIV Y / N Cortisone Medicine Y / N Hemophelia Y / N Radiation Y / N Weight Loss Y / N

Alzheimers Y / N Diabetes Y / N Hepatitus A Y / N Renal Dialysis Y / N Rhematic Fever Y / N

Anaphlaxis Y / N Drug Addiction Y / N Hepatitus B or C Y / N Rhemuatism Y / N Scarlet Fever Y / N

Anemia Y / N Easily Winded Y / N Herpes Y / N Shingles Y / N Sickle Cell Dis. Y / N

Angina Y / N Emphysima Y / N High Blood Pressure Y / N Sinus Trouble Y / N Spina Bifida Y / N

Arthritu/Gout Y / N Epilepsy or Seizures Y / N High Cholesterol Y / N Stomach/Intes Disease Y / N

Art Heart Valve Y / N Excessive Bleeding Y / N Hives or Rash Y / N Stroke Y / N Swelling of Limbs Y / N

Artificial Joint Y / N Excessive Thirst Y / N Hypoglycemia Y / N Thyroid Disease Y / N Chest Pains Y / N

Asthma Y / N Fainting/Dizziness Y / N Irregular Heart Beat Y / N Heart Attack Y / N Osteoporosis Y / N

Blood Disease Y / N Frequent Cough Y / N Kidney Problems Y / N Tonsillitis Y / N Heart Murmur Y / N

Blood Transfusion Y / N Frequent Diarrhea Y / N Leukemia Y / N Cold Sore/ Fever Blisters Y / N

Breathing Problems Y / N Freq. Headaches Y / N Liver Disease Y / N Pain in Jaw Joints Y / N Tumors or Growth Y / N

Bruise Easily Y / N Genital Herpes Y / N Low Blood Pressure Y / N Congenital Hear Disorder Y / N Pacemaker Y / N

Cancer Y / N Glaucoma Y / N Lung Disease Y / N Parathyroid Dis. Y / N Ulcers Y / N

Chemotherapy Y / N Hay Fever Y / N Mitral Valve Prolapse Y / N Convulsions Y / N Psychiatric Care Y / N

Yellow Jaundice Y / N Any other Disease not Listed ____

Are you allergic any of the following (please circle) Latex, Penicillin, Local Anesthtics, Codiene, Sufla, Sedatives/Barbituates, Aspirin,

Are you taking any of the following: (please circle) Blood Thinners, High Blood Pressure Medication, Antidepressants, Insulin, Nitroglycerin, Coritsone, Osteoporosis (bone density) medicine

Patient Signature:___________________________________ Date:_____________________