PIKE ROAD DENTAL

31 Bridge Street,
Pike Road, AL 36064
334-819-7377

First name: _____ Middle Initial: _____ Last name: _____

Street: _____ City: _____ Zip: _____ State: ____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

DOB: _____ Sex: ◯ M ◯ F Marital Status: ◯ Married ◯ Single Social Sec. #: _____

Email: _____ Referred by: _____

Primary Insurance:

Employer: _____

Insurance Company: _____

Contract/Policy #: _____

Group #: _____

Subscriber's Name: _____

DOB: _____ Social Sec. #: _____

Secondary Insurance:

Employer: _____

Insurance Company: _____

Contract/Policy #: _____

Group #: _____

Subscriber's Name: _____

DOB: _____ Social Sec. #: _____

Party responsible for payment (if not self):

Name: _____ Phone: _____ DOB: _____

Address: _____

Medical History/Information:

Primary Physician: _____ Phone: _____ Last Physical: _____

General Health Condition: ◯ Excellent ◯ Good ◯ Fair ◯ Poor

Are you currently on medication? ◯ Yes ◯ No If so, for what purpose: _____

List ALL current medications: _____

Have you ever taken bone medication? ◯ Yes ◯ No

Have you ever been treated for:

Mitral valve prolapse	◯Y ◯N	Venereal disease	◯Y ◯N	Hepatitis	◯Y ◯N
Heart disease	◯Y ◯N	HIV / AIDS	◯Y ◯N	Arthritis	◯Y ◯N
Rheumatic fever	◯Y ◯N	Ulcers	◯Y ◯N	Stroke	◯Y ◯N
Heart murmur	◯Y ◯N	Lung disease	◯Y ◯N	Glaucoma	◯Y ◯N
High blood pressure	◯Y ◯N	Diabetes	◯Y ◯N	Joint replacement	◯Y ◯N
Low blood pressure	◯Y ◯N	Epilepsy	◯Y ◯N	Cancer	◯Y ◯N
Congenital heart lesions	◯Y ◯N	Hay fever	◯Y ◯N	HPV	◯Y ◯N
Jaundice	◯Y ◯N	Sinus trouble	◯Y ◯N	Do you smoke?	☐ Y ☐ N
Tuberculosis	◯Y ◯N	Asthma	◯Y ◯N	If yes, how much?	
		Bone density	◯Y ◯N		

Are you allergic to any of the following?

Penicillin ◯Y ◯N Codeine ◯Y ◯N Latex ◯Y ◯N Local Injected Anesthetics ◯Y ◯N

☐ Other- please list ALL allergies: _____

☐ Other - please list below _____

Do you have prolonged bleeding? ◯ Yes ◯ No Are you pregnant? ◯ Yes ◯ No