ACQUAINTANCE INFORMATION

Date _____

Patient Name _____

Preferred Name _____ Spouse's Name _____

Address _____

_____

Birthdate _____ Social Security # _____

Home Number_____ Work Number_____ Cell Number_____

Email Address _____

How did you learn about our office?_____ Dentist _____

Employer_____ Employer Address _____

Insured's Name_____Insured's Soc. Sec. #_____

Insured's Birthdate_____ Relationship to Patient _____

Insured's Employer _____Occupation _____

Insured's Work Number _____ Insurance Company_____

Group No._____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? yes☐ no☐ if yes: _____

Name of nearest relative not living with you _____Phone_____

Complete Address _____

Whom may we notify in case of an emergency?

Name _____ Phone_____Relationship to you _____

I give consent to the office of Dr. Kenneth R. Levine to obtain and to release any and all information pertaining to my medical history, insurance or billing questions.

Signature_____

(OVER)

Medical History

Name of Physician _____ Last Appointment _____ Phone _____

Are you pregnant? Yes ☐ No ☐ If yes, anticipated delivery date _____

Do you wear contact lenses? Yes ☐ No ☐

Check a definite answer for each question:

Yes ☐ No ☐ Any change in your health in the past two years?

Yes ☐ No ☐ Are you currently under the care of a physician?
If yes, describe your treatment _____

Yes ☐ No ☐ Have you had any medical treatment or physician visit of any kind in the last two years?
If yes, describe _____

Yes ☐ No ☐ Have you ever had any surgical operation of any kind?
If yes, describe the surgery _____

Yes ☐ No ☐ Were you transfused at that time? _____

Yes ☐ No ☐ Have you been advised by a physician of the need for any surgery or treatment?
What treatment of surgery? _____

Do you have, or have you ever been treated for any of the following:

Yes ☐ No ☐ Allergy
Yes ☐ No ☐ Arthritis
Yes ☐ No ☐ Chronic Sinusitis
Yes ☐ No ☐ Glaucoma
Yes ☐ No ☐ Thyroid Condition
Yes ☐ No ☐ Anemia, Sickle Cell Disease
Yes ☐ No ☐ Fainting
Yes ☐ No ☐ Radiation/Chemical Therapy
Yes ☐ No ☐ Enzyme Deficiency
Yes ☐ No ☐ Asthma
Yes ☐ No ☐ Chemical/Alcohol Dependency

Yes ☐ No ☐ Mental Disorders
Yes ☐ No ☐ AIDS or HIV
Yes ☐ No ☐ Tuberculosis
Yes ☐ No ☐ Diabetes
Yes ☐ No ☐ Epilepsy, Seizures
Yes ☐ No ☐ Prolonged Bleeding
Yes ☐ No ☐ GI Problems
Yes ☐ No ☐ Kidney Disorder
Yes ☐ No ☐ Hepatitis
Yes ☐ No ☐ Ulcers
Yes ☐ No ☐ Anorexia, Bulimia

Yes ☐ No ☐ Heart Problems
Yes ☐ No ☐ Heart Murmur
Yes ☐ No ☐ Mitral Valve Prolapse
Yes ☐ No ☐ Valve Replacement
Yes ☐ No ☐ Low Blood Pressure
Yes ☐ No ☐ High Blood Pressure
Yes ☐ No ☐ Pacemaker Type
Yes ☐ No ☐ Shortness of Breath
Yes ☐ No ☐ Rheumatic Fever
Yes ☐ No ☐ Hip or Joint Replacement
Yes ☐ No ☐ Venereal Disease/Herpes II
Yes ☐ No ☐ Sleep Apnea

Yes ☐ No ☐ Have you ever had an allergic reaction or been told not to take any medication?
If yes, describe _____

Yes ☐ No ☐ Are you currently taking any prescription drugs of any kind?
(ex. Birth Control, Hormone, Diet) If yes, describe _____

Yes ☐ No ☐ Are you currently taking any non-prescription drugs?

Yes ☐ No ☐ Do you use any tobacco products? Daily intake _____

Yes ☐ No ☐ Have you ever had Botox and/or Dermal Fillers? When _____

History of Biophosphonates? (Oral) Fosamax, Actonel, Boniva, (IV) Zometa, Aredia
When and for how long? _____

I CERTIFY THE ABOVE TO BE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE

SIGNATURE _____ DATE _____