Donald Hills, D.D.S. 136 Woodbury Road Woodbury, NY 11797 (516) 367-9396

## PATIENT ACQUAINTANCE FORM

Name:		Today's Date:
City:	State:Work Phone:Social Security	Zip:
Home Phone:	Work Phone:	Cell Phone:
Birthdate:	Social Security	· #:
Name of Responsible Party	•	
Insurance Coverage:	Employers's Name:	
Referred By:		
Y N [][] Allergy to Penicillin [][] Allergies to other drugs [][] Allergies to anesthetics [][] Heart Ailments [][] Radiation Treatments [][] Excessive Bleeding [][] Anemia/Blood Disorder [][] Asthma	I I I I Kidnev Disorder	ies [][] Sinus Disorder [][] Ulcer or Colitis [][] Thyroid Disorder [][] Eye Disorder [][] Tonsillitis [][] Physical/Mental Handicap [][] Anxiety/Apprehension [][] Other
<ol> <li>Have you ever had infect</li> <li>Do you have a prosthetic</li> <li>Have you recieved coror</li> <li>Are you taking now, or he (examples: Fosamax, Are</li> <li>Are you taking any protest</li> </ol>	c cardiac valve? hary artery stents? have you ever taken, biphosphaedia, Zometa) hase inhibitors?	Y N Y N Y N
7) List ANY and ALL aller 8) List ANY and ALL med	ications you are currently taking	ng:
9) Name of Physician:	Physici Physici	an's Phone #:
Signature:	Today's Dat	e:
Dentist's Signature:	Today's Dat	e: