Patient Name _____ Phone _____

HEALTH QUESTIONNAIRE & MEDICAL INFORMATION

DO YOU HAVE OR HAVE EVER HAD:

Heart Disease	YES	NO	Venereal Disease / STD's	YES	NO
Specific Heart Disease Listed Below			Kidney Problems	YES	NO
Angina	YES	NO	Respiratory Problems		
Arteriosclerosis	YES	NO	For example: Asthma / Emphysema	YES	NO
Heart Murmur	YES	NO	Hepatitis, Jaundice	YES	NO
Congestive Heart Failure	YES	NO	Anemia	YES	NO
Heart Attack	YES	NO	Night Sweats	YES	NO
Mitral Valve Prolapse	YES	NO	Unexplained Weight Loss / Fever	YES	NO
Pacemaker Surgery	YES	NO	Blood Transfusion	YES	NO
Bypass Surgery	YES	NO	Test for HIV for AIDS	N/A POS	NEG
High Blood Pressure	YES	NO	Test for TB	N/A POS	NEG
Low Blood Pressure	YES	NO	Radiation Treatment	YES	NO
Rheumatic Fever	YES	NO	Chemotherapy	YES	NO
Cholesterol Problems	YES	NO	Cancer: Please list with year	YES	NO
Diabetes	YES	NO	_____		
Dry Mouth	YES	NO	_____		
Joint Replacement or Damage	YES	NO	_____		
Seizures	YES	NO	Surgery: Please list with year	YES	NO
Fainting Spells	YES	NO	_____		
Stomach Ulcers	YES	NO	_____		
Dementia / Alzheimer's Disease	YES	NO			

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO:

Any local anesthetics	YES	NO	Codeine	YES	NO
Barbituates, Sedatives, Valium	YES	NO	Aspirin or Ibuprofin	YES	NO
Heart Medications	YES	NO	Latex	YES	NO
Penicillin	YES	NO	Other allergies: please list	YES	NO
Other antibiotics	YES	NO			

_____ _____

_____ _____

ARE YOU TAKING ANY OF THE FOLLOWING:

Anticoagulants (blood thinners)	YES	NO	Nitroglycerin	YES	NO
Aspirin/Anti-inflammatory drugs	YES	NO	Antibiotics or Sulfa Drugs	YES	NO
Heart Medications	YES	NO	Cortisone or Steroids	YES	NO
Medicines for High Blood Pressure	YES	NO	Tranquilizers or Antidepressants	YES	NO
Insulin, Micronase, or Glucotrol	YES	NO	Birth Control Pills	YES	NO
Have you ever taken any Bisphosphonate drugs? (Fosamax, Boniva, Aredia, Zometa, Actonel)	YES	NO	Do you use Tobacco, Vaping, Marijuana, or E-Cigarette products	YES	NO
			Do you consume alcohol?	YES	NO

List Medications & Herbal Remedies	Dosage	Frequency	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- Have you ever had to be premedicated for dental work? YES NO
- Please describe any current or recent medical treatment, impending operations, pregnancies, or other information we should be aware of: _____

HEALTH QUESTIONNAIRE & MEDICAL INFORMATION

PATIENT REGISTRATION & INSURANCE

Patient's Name _____ Date _____

Address _____ Birthdate _____

City _____ Zip _____ Home Phone _____

E-mail _____ Cell # _____

Please circle: Patient's Marital Status: S M W D Patient's Sex: F M

Employed by _____ Occupation _____

Employer's Address _____

Work Phone _____ EXT _____ May we call you at your work number? YES NO

Spouse's Name **(Or parent's name if patient is a minor)** _____

Spouse's Address ("Same" acceptable) _____

Spouse's Employer & Address _____

Work Phone _____ EXT _____ May we call them at this work number? YES NO

Your Social Security # _____ Spouse's Social Security # _____

Physician Name _____ Last Visit _____

Whom should we contact in case of emergency? _____ Phone _____

Whom may we thank for referring you? _____

Hobbies or interests? _____

COMPLETE THIS SECTION IF YOU HAVE DENTAL INSURANCE(S)

Primary Insurance	Secondary Insurance
Insured's Name _____	Insured's Name _____
Group # _____ SS# _____	Group # _____ SS# _____
Employer _____	Employer _____
Insurance Carrier _____	Insurance Carrier _____
Insured's Birthdate _____	Insured's Birthdate _____

READ CAREFULLY AND UNDERSTAND WHAT YOUR SIGNATURE MEANS. Your signature below serves many purposes. It indicates you have reviewed your medical history on the other side of this paper and updated and corrected it as appropriate. It also indicates you have reviewed your personal registration information above (especially your phone numbers) to ensure that it is correct. Also, your signature below shall constitute your "Signature on File" with your insurance company (if applicable) for assignment of your insurance benefits to West Bay Dental and the release of information to all my insurance carriers. And finally, the undersigned agrees, whether or not he/she is insured, that in consideration of the services rendered to the patient, he or she individually obligates themselves to pay this account upon receipt of the initial bill for the above mentioned services and/or acknowledges that he or she is primarily responsible for payment of the account notwithstanding the existence of other sources of payment, unless previous financial arrangements have been made with the Financial Coordinator. A 1.5% (18% APR) monthly service charge is assessed on ALL balances over 30 days. Your signature also is a promise that you will keep all scheduled appointments.

Signature _____ Date _____ Signature _____ Date _____

Signature _____ Date _____ Signature _____ Date _____

All information is protected by Doctor-Patient Confidentiality.
You will be held responsible if statements or representations are untrue.
West Bay Dental • 401 S. Euclid Avenue • Bay City, MI 48706 • (989) 686-5410
Please sign once per visit.

PATIENT REGISTRATION / INSURANCE

Name:

BLOODTHINNERS / ANTIPLATELETS / BISPHOSPHONATES
Please circle any medications / natural supplements you currently take and any Bisphosphonate you have EVER taken:

ANTICOAGULANTS (Decreases the clotting ability of the blood) None _____

Brand	Generic	Brand	Generic
Alteplase	Actilyse/Actilyse 20	Fragmin	delteparin
Ardeparin	Inderparin	Innohep	Tinzaparin sodium
Arixtra	fondaparinux	Jantoven	warfarin
	Aspirin	Lovenox	enoxaparin
Coumnadin	warfarin	Pradaxa	dabigatran
Dalteparin	Fragmin PF	Savaysa	edoxaban Tosylate
Danaparoid		Warfarin	
Eliquis	apixaban	Xarelto	rivaroxzban
Enoxaparin	Thrombiflo/Cutmox		heparin
Fondaparinux	Arixtra PF		

NATURAL SUPPLEMENTS
Garlic / Ginsing / Ginkoba

ANTIPLATELET AGENTS (Keeps blood clots from forming by preventing clots from sticking together) None _____

Brand	Generic	Brand	Generic
Abcixmab	Reopro	Plavix	Clopidogrel
Brilinta	Ticagrelor	Pletal	Cilostazol
Effient	Prasugrel	Ticlopidine	
Eptifibatide	Integrillin	Tirofiban	Aggrastat
Genericonlyno	Dipyridamole	Zonitivity	Vorapaxar
Persantine	Dipyridamole		

BISPHOSPHONATES None _____

Brand	Generic	Brand	Generic
Aclasta	Zoledronic Acid	Atelvia	Risedronate sodium
Actonel	Risedronate sodium	Binosto	Alendronate Sodium
Aredia	Pamidronate Disodium	Boniva	Ibandronate sodium
Skelid	Tiludronate Disodium	Didronel	Etidronate Disodium
Pamidronate	Ibandronate sodium		
Reclast	Zoledronic Acid		
Fosamax	Alendronate sodium		
Fosamax Plus D	Alendronate sodium plus Cholecalciferol		
Actonel w/calcium	Risedronate sodium and calcium carbonate		
Zometa	Zoledronic Acid		

Signature:_____ Date:_____ Signature:_____ Date:_____

Signature:_____ Date:_____ Signature:_____ Date:_____

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