RAYMOND J. STEINER, D.D.S. - PERIODONTICS

Name (First) (Last)	Do you have dental insurance? _____ Yes ____ No Do you have a secondary insurance? _____ Yes ____ No
Address (Street)	**If yes, complete below**
City, State, Zip Code	Insured SS#___________________Date of Birth ______________
Home Phone Work Phone Cell Phone	Primary Insurance Carrier _________________________________
Date of Birth Marital Status Sex	Insured Employer ____
Employer/Occupation Social Security #	Secondary Insurance Carrier _______________________________
Dentist's Name Referred By	Insured Employer ____
E-mail Address	
Emergency Contact (Name)(Phone)(Relationship)	

List names of any medications you are currently taking or write none:

____

List names of allergies or sensitivities to medications or write none:

____

List hospitalizations or surgical operations with dates:

____

Have you ever had any of the following?

___ Yes ___ No Asthma
___ Yes ___ No Tuberculosis
___ Yes ___ No Organ Transplant
___ Yes ___ No Prosthetic Heart Valve
___ Yes ___ No Bacterial Endocarditis
___ Yes ___ No Congenital Heart Malformations
___ Yes ___ No Heart Transplant
___ Yes ___ No Heart Disease/ Attack
___ Yes ___ No Angina Pectoris
___ Yes ___ No Pacemaker
___ Yes ___ No Stroke
___ Yes ___ No High Cholesterol
___ Yes ___ No High Blood Pressure
___ Yes ___ No Epilepsy or Seizures
___ Yes ___ No Nervousness/Worry
___ Yes ___ No Abnormal Stress
___ Yes ___ No Psychiatric Treatment
___ Yes ___ No Thyroid Disease (or Goiter)
___ Yes ___ No Cancer or Tumor
___ Yes ___ No Radiation Therapy
___ Yes ___ No Chemotherapy (Cancer, Tumor)

___ Yes ___ No Bruise Easily
___ Yes ___ No Anemia
___ Yes ___ No Acid Reflux/GERD
___ Yes ___ No Stomach/Intestinal Ulcer
___ Yes ___ No Kidney or Bladder Disease
___ Yes ___ No Diabetes
___ Yes ___ No Glaucoma
___ Yes ___ No Arthritis
___ Yes ___ No Osteopenia
___ Yes ___ No Osteoporosis
___ Yes ___ No Hepatitis (Yellow Jaundice)
___ Yes ___ No AIDS
___ Yes ___ No HIV Infection
___ Yes ___ No Sexually Transmitted Disease
___ Yes ___ No Blood Transfusions
___ Yes ___ No Frequent Headaches
___ Yes ___ No Drug/Alcohol Dependency
___ Yes ___ No Illicit Drug Use
___ Yes ___ No Smokeless Tobacco Use
___ Yes ___ No Smoking
___ Yes ___ No Artificial Joint Replacement

Females: Are you pregnant? ___Yes ___ No **(If yes, Date of delivery**) ________________________

Do you have any disease, condition, or problem not listed? ___Yes ___ No
If yes, please explain:

____

To the best of my knowledge all of the above answers are true and correct. If there are any changes in my health status I will inform Dr. Steiner at my next appointment.

Signature of Patient (or Legal Guardian) ____________________________________ Date______________________