JOSHUA D. PRUDEN, DDS • JAMES W. VARGO, DDS

92 BROOKSHIRE LANE, BECKLEY, WV 25801

CELL _____

NAME _____ DATE OF BIRTH _____ HOME PHONE _____

REFERRING DENTIST _____ YOUR MEDICAL PROVIDER _____

MEDICAL HISTORY

CIRCLE ANY OF THE FOLLOWING YOU HAVE HAD OR PRESENTLY HAVE:

HEART DISEASE OR ATTACK
ANGINA PECTORIS
HIGH BLOOD PRESSURE
HEART MURMUR
RHEUMATIC FEVER
CONGENITAL HEART LESIONS
MITRAL VALVE PROLAPSE
ARTIFICIAL HEART VALVE
HEART PACEMAKER
HEART SURGERY
ARTIFICIAL JOINTS-HIP-KNEE
ANEMIA
STROKE
PAIN IN JAW JOINTS

ULCERS
AIDS, ARC, HIV POS
HEPATITIS A (INFECTIOUS)
HEPATITIS B (SERUM)
LIVER DISEASE
BLOOD TRANSFUSION
DRUG ADDICTION
HEMOPHILLIA-BLEEDING PROBLEMS
EPILEPSY OR SEIZURES
NERVOUSNESS
PSYCHIATRIC TREATMENT
GLAUCOMA
CHEMOTHERAPY-CANCER-LEUKEMIA
KIDNEY TROUBLE

COSMETIC SURGERY
BRUISE EASILY
EMPHYSEMA
TUBERCULOSIS (TB)
ASTHMA
SINUS TROUBLE
ALLERGIES OR HIVES
DIABETES
THYROID DISEASE
RADIATION
ARTHRITIS
CORTISONE MEDS
ALCOHOLISM

Do you take ORAL BISPHOSPHONATE medicines like Fosamax (Alendronate), Actonel (Risedronate), Boniva (Ibandronate), Skelid (Tiludronate), Didronel (Etidronate)? _____ If yes, how long have you been taking it? _____

_____

Have you had IV BISPHONSPHONATES like Aredia (Pamidronate), Zometa (Zoledronate), Didronel (Etidronate)? _____
If yes, when? _____

Are you under a physicians care now? If so, for what? _____

List current medications (i.e. Aspirin & all prescription meds) _____

_____

_____

Females—Are you pregnant? _____

Are you allergic to any medications, substances, or latex? _____

**Is there any other medical or dental information that you feel I should know about? _____

_____

_____

PATIENT SIGNATURE **DATE**
If underage Parent/Guardian Signature

REVIEW OF HISTORY

OFFICE USE: _____ DATE _____ DENTIST'S INITIAL _____ DATE

OFFICE USE: _____ DATE _____ DENTIST'S INITIAL _____ DATE

OFFICE USE: _____ DATE _____ DENTIST'S INITIAL _____ DATE

OFFICE USE: _____ DATE _____ DENTIST'S INITIAL _____ DATE

OFFICE USE: _____ DATE _____ DENTIST'S INITIAL _____ DATE

(Please see front and back of sheet)

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92 BROOKSHIRE LANE
BECKLEY, WV 25801
304-255-0020
304-255-0036 fax

PATIENT REGISTRATION

PATIENT'S
NAME _____

MAILING
ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHYSICAL ADDRESS
(if different) _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ SS# _____ SEX – M - F

EMPLOYER _____

EMPLOYER'S ADDRESS _____ EMPLOYER PHONE _____

NAME OF SPOUSE _____

SPOUSE'S EMPLOYER _____

EMPLOYER'S ADDRESS _____ EMPLOYER PHONE _____

IF A CHILD, PARENT'S NAME _____

DO YOU HAVE DENTAL INSURANCE? _____ NAME OF DENTAL INSURANCE? _____

ADDRESS OF DENTAL INSURANCE COMPANY _____

POLICY HOLDER'S NAME _____

POLICY HOLDER'S SS# or ID# _____ DATE OF BIRTH _____

_____ **DATE** _____
PATIENT SIGNATURE
IF UNDER AGE PARENT/GUARDIAN SIGNATURE

(Please see front and back of sheet)