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BELMAR PARK DENTAL CARE, P.C.
David G. Collins, DDS, FICOI
Joseph Suslik, DDS

## PATIENT INFORMATION

Patient's Name _____
Address _____
City _____ State _____ Zip _____
Email Address _____
Employer Name _____
Employer Address _____
City _____ State _____ Zip _____

Home Phone _____
Cell Phone _____
Date of Birth _____ Sex M F
Social Security # _____
Business Phone _____
Your Position _____

## INSURANCE INFORMATION

Do you have Dental Insurance? Yes No
Name of Insured Person _____
Social Security # of Insured _____
Insurance Company _____
Address _____

Phone _____
Insured D.O.B. _____
Group # _____
Effective Date _____
Plan Name or Number _____

## UPDATED MEDICAL HISTORY

Your Name _____ Today's Date _____

Physician's Name _____ Phone # _____

Are you under a doctor's care now? Why? _____ YES NO

Have you been hospitalized during the past two years? Why? _____ YES NO

Are you taking any medications, pills or drugs? What? _____ YES NO

Please list any allergies to drugs, medications, anesthetics or latex _____

Please tell us if you have had any of the following by checking the appropriate box:

- ❑ Bacterial Endocarditis
- ❑ Heart Murmur
- ❑ Irregular Heart Beat
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Rheumatic Heart Fever
- ❑ Rheumatic Heart Disease
- ❑ Artificial Heart Valves
- ❑ Congenital Heart Lesion
- ❑ Heart Attack _____ year
- ❑ Angina/Chest Pain
- ❑ Heart Pacemaker _____ year
- ❑ Heart Surgery _____ year
- ❑ Congestive Heart Failure
- ❑ Stomach Problems/Reflux
- ❑ Hemophelia
- ❑ Blood Disease
- ❑ Sickle Cell Anemia
- ❑ Anemia/Blood Problems
- ❑ Excessive Bleeding
- ❑ Asthma
- ❑ Respiratory Disease
- ❑ Shortness of Breath
- ❑ Hay Fever
- ❑ Sinus Problems
- ❑ Tuberculosis
- ❑ Eye Disorder/Glaucoma
- ❑ AIDS/HIV
- ❑ Immunosupressive Disorders/ARC
- ❑ Any Artificial Replacement Artificial Knee, Hip, Joint, Pins, Plate _____ year
- ❑ Rheumatism/Arthritis
- ❑ Neurological Problems
- ❑ Epilepsy/Seizures
- ❑ Psychiatric Problems
- ❑ Emotional Problems
- ❑ Alcoholism
- ❑ Chemical Dependency
- ❑ Drug Addiction
- ❑ Tobacco Use
- ❑ Malignancies
- ❑ Cancers, Tumors, Growths
- ❑ Radiation Treatments
- ❑ Diabetes
- ❑ Kidney Problems
- ❑ Dialysis
- ❑ Liver Problems
- ❑ Hepatitis
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Ulcer/Colitis
- ❑ Venereal Disease
- ❑ Herpes
- ❑ Fever Blisters
- ❑ Latex Allergy
- ❑ Pregnant _____ months
- ❑ Planning to be pregnant soon
- ❑ Oral Contraceptives

Have you ever taken medication for osteoporosis or to improve bone density? _____ YES NO

Please list any other MEDICAL CONDITIONS not mentioned above _____

X _____ X _____