TODAY’S DATE:________________ SOCIAL SECURITY#:_________________________

PATIENT’S NAME: ____________________________________ DATE OF BIRTH: _________________

PHYSICAL ADDRESS:____

MAILING ADDRESS(IF DIFFERENT): ____

CITY:_______________________________ STATE:_____________ ZIP CODE:________________

HOME PHONE:____________________________ CELL PHONE: ___________________________

EMAIL: ____

PLACE OF EMPLOYMENT: ___________________________WORK PHONE: _____________________

EMERGENCY CONTACT PERSON: ____________________________ PHONE: _____________________

CIRCLE ANY OF THE FOLLOWING CONDITIONS YOU HAVE OR HAVE EVER HAD:

A. High Blood Pressure
B. Heart Attack or Heart Trouble
C. Heart Valve Replacement
D. Pacemaker
E. Joint Replacement
F. Stroke
G. Acid Reflux (GERD)
H. Sleep Apnea
I. Cancer
J. Diabetes
K. Bleeding Problems
L. Hepatitis or Liver Disease
M. HIV/AIDS
N. Tuberculosis
O. Kidney Problems
P. Stomach Ulcers
Q. Osteoporosis
R. Glaucoma
S. Sinus Problems
T. Asthma
U. COPD
V. Seizures
W. List of Allergies to ANY Medications
X. Latex Allergy
Y. Tobacco Use
Z. Psychiatric Problems

***FOR WOMEN ONLY: ARE YOU PREGNANT? ______________ NURSING? _____________

BIRTH CONTROL? _______________

ARE YOU TAKING ANY MEDICATIONS? YES (OR) NO …IF YES, PLEASE LIST THEM:

____

ARE YOU ALLERGICE TO ANY OF THE FOLLOWING? (PLEASE CIRCLE)

Aspirin	Penicillin	Sulfa Drugs
Metal	Latex	Acrylic
OTHER: ________________________________		NONE

PLEASE LIST ANY PREVIOUS SURGERIES: ____
____

DO YOU TAKE OR HAVE YOUR EVER TAKEN ANY MEDICATIONS FOR OSTEOPOROSIS (FOR YOUR BONES)? ____

DO YOU SNORE OR HAVE YOU BEEN TOLD YOU SNORE? (CIRCLE ONE) YES OR NO

HAVE YOU HAD A SLEEP STUDY OR BEEN TOLD YOU NEED ONE? (CIRCLE ONE) YES OR NO

I CERTIFY THAT THE INFORMATION I HAVE GIVEN IS TRUE TO THE BEST OF MY KNOWLEDGE:

PATIENT SIGNATURE/GUARDIAN SIGNATURE ______________________________
DATE ___________________