PATIENT INFORMATION UPDATE

Patient Name____ Male______ Female______

Birthdate______________________ Social Security Number_______________________

Address________________________________ City__________ State_______ Zip________

Phone Number-Home___________________ Work_______________ Cell_________________

E-mail address_____________________________________

Person Responsible for account if other than patient

Patient Name____ Male______ Female______

Birthdate______________________ Social Security Number_______________________

Address________________________________ City__________ State_______ Zip________

Phone Number-Home___________________ Work_______________ Cell_________________

E-mail address_____________________________________

Employer____________________________________ Address_____________________________

Primary Insurance Policy Holder

Name_________________________________ Realtionship to Patient_________________________

Birthdate____________________ Social Security Number_________________________________

Employer_________________________________ Address__________________________________

Group Policy Number_______________________ Insurance Company________________________

Secondary Insurance Policy Holder

Name_________________________________ Realtionship to Patient_________________________

Birthdate____________________ Social Security Number_________________________________

Employer_________________________________ Address__________________________________

Group Policy Number_______________________ Insurance Company________________

MEDICATION: Are you taking, or are supposed to be taking any medication (prescription or over the counter) diet supplements or vitamins? YES NO

If yes, drug and dosage

MEDICATION	DOSAGE

ALLERGIES: Do you have allergies of have ever had an allergic reaction?
YES NO

If yes, please list

ALLERGIES	REACTION

MEDICAL CONDITIONS: Do you have or have you had any of the following diseases, conditions or problem? If yes please specify?

Cardiovascular/ heart problems? YES NO
Heart murmur, artificial valves, heart attack, congestive heart failure, high or low blood pressure, other

Neurologic problem YES NO
Stroke, TIA, Epilepsy, Parkinson's, dizzy spells, dementia, Alzheimer's, Bipolar, Depression, anxiety, other

Musculoskeletal / Connective tissue disorder YES NO
Osteoporosis, Arthritis, TMD, other

Respiratory/ Lung problems? YES NO
Asthma, COPD, Sleep Apnea, other

Blood Disorder? YES NO
Anemia, leukemia, bleeding disorders, other

Endocrine disorder? YES NO
Diabetes TYPE1, TYPE2, thyroid problems, other

Gastrointestinal disorder? YES NO
Acid reflux, heartburn, other

Infectious Disease? YES NO
HIV, AIDS, STDs, Hepatitis, other

Immunosuppression YES NO

Do you have any other diseases not listed above?

Drs. Mancuso & Mancuso P.C.

7930 Blondo St. Omaha, Ne 68134

G. John Mancuso D.D.S. Sarah T. Billesbach D.D.S. Benjamin J. Mancuso D.D.S.

GENERAL INFORMATION:

Emergency Contact:

Phone:

Preferred method to contact you email phone text

Marital status: Single Married Divorced Separated Widow

Name of school (if attending):

Who referred you to our office?

Last Dental Appointment:

Which Doctor do you see?

Dr. Sarah Dr. Ben Dr. John

I hereby authorize payment directly to above name dentist as well as release of information needed for insurance purposes

Signature_______________________________ Date:__/___/___

MEDICAL HISTORY:

What is your impression of your health? Good Fair Poor

Date of last physical exam (month/ year) /

Are you under the care of a physician YES NO

If yes, what is /are the condition(s) being treated?

Have you had any serious illness or been hospitalized in last 5 years? YES NO

If yes what was the illness

Have you had an organ transplant? YES NO

Have you had an orthopedic joint replacement? YES NO

If yes, what joint and when was it replaced

Are you pregnant? YES NO

If yes, how many weeks?

Have you ever taken or are you scheduled to begin taking?

Oral bisphosphonates (Fosamax, Boniva, Actonel) **YES NO**

If yes, drug and dosage

Intravenous bisphosphonates (Aredia or Zometa) **YES NO**

If yes, drug and dosage