Patient Information

Name: _____ Birth Date: _____
Last First MI

Please circle all that apply: Male Female Married Single Child SS#_____

Address: _____
Street Apartment #

_____
City State Zip Code

Home Phone: _____ Work: _____ Ext_____

Cell: _____ E-Mail: _____

I authorize Dr. Davis' office to contact me and leave messages and/or appointment reminders at the above numbers and/or via e-mail, letter or postcard.

I prefer to be contacted at (circle one): Home Work Cellular None (I request not to be contacted.)

Insurance Information

Primary Insurance Carrier_____ **Group Number**_____

Name of Insured/Responsible Party_____ Birth Date_____ ID#_____

Secondary Insurance Carrier_____ **Group Number**_____

Name of Insured/Responsible Party_____ Birth Date_____ ID#_____

Health Information

MEDICATIONS_____

ALLERGIES_____

Name of Physician:_____ Phone:_____

MEDICAL CONDITIONS: (Please circle all that apply)

Cardiovascular: Heart Bypass Surgery-Angina-Heart Attack-High Blood Pressure-Stroke-Heart Valve Replacement or Defective Heart Valve where antibiotic premedication is recommended by physician.

Respiratory: Smoker (_____pk/d)-Former Smoker -Asthma-Emphysema-Bronchitis-Tuberculosis-Cough-Sinus Disease-Allergies

Endocrine: Diabetes (Control: Good, Fair, Poor)-Thyroid-Adrenal Gland Disease-Steroid Therapy (hydrocortisone-like medication)

Gastrointestinal: Hepatitis (A, B, C)-Ulcers-GERD-Smokeless Tobacco-Mouth Ulcers-Dry Mouth-Sore Throat-Difficult Swallowing

Musculoskeletal: Artificial Joint (hip/knee) where antibiotic premedication is recommended by physician-Arthritis-Osteoporosis

Hematological: Anticoagulant Therapy (Coumadin/warfarin/heparin)-Bleeding Disorder-Anemia-Transfusion

Neurological: Seizures-Headaches-Paralysis-Memory Disorders-Alzheimers-Vision Disturbances-Facial Numbness

Genitourinary: Pregnancy-Kidney Disease-Kidney Infection

Immunological: Cancer-Cancer Treatment involving the use of bisphosphonate drugs-Organ Transplant-Lupus-HIV

Dermatological: Rashes-Ulcerations-Cold Sores-Skin Cancer-Dry Eyes

Dental Care: Last dental visit (mo/yr) _____ Reason: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

_____
Signature of patient, parent or guardian Date