Date of last medical exam: What was this exam for?

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: Are you currently under a physician’s care? No Yes If yes, nature of care: Please list all the names and phone numbers of the physicians who are currently providing you care:

1.

2.

3.

Please list any medications you are currently taking and dosages:

1.

2.

3.

4.

Do you take a Pre-medication prior to dental appointments? NO YES

If “YES”, for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES If so, when did the treatment begin? When did the treatment end?

Are you currently taking any blood thinners? NO YES Which Drug:

|  |  |  |
| --- | --- | --- |
| Women: Are you pregnant? | No | Yes |
| If no, are you planning a pregnancy in the near future? | No | Yes |
| Are you a nursing mother? | No | Yes |

Are you allergic or have you had a reaction to:

1. Local anesthetics No Yes
2. Penicillin No Yes
3. Aspirin, Ibuprofen or Tylenol No Yes
4. Codeine, Valium or sedatives No Yes
5. Latex or Metals No Yes
6. Other (please specify)

***For the following questions circle yes or no.***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Anemia or Blood Disorder? | No | Yes | Hepatitis, Any Form | No | Yes |
| Arthritis, Rheumatism or other inflammatory disease? | No | Yes | Joint Replacement? When placed? | No | Yes |
| Asthma | No | Yes | Kidney Disease | No | Yes |
| Abnormal Bleeding from a cut? | No | Yes | Liver Disease (including Jaundice) | No | Yes |
| Cancer or Tumor? | No | Yes | Sore/Enlarged Lymph Nodes | No | Yes |
| Diabetes | No | Yes | High Blood Pressure | No | Yes |
| Emphysema or other Respiratory/Lung Illnesses | No | Yes | Low Blood Pressure | No | Yes |
| Epilepsy | No | Yes | Radiation or Chemotherapy Treatment | No | Yes |
| Fainting or Dizzy Spells | No | Yes | Thyroid Disease | No | Yes |
| Glaucoma | No | Yes | Slow-Healing Mouth Sores | No | Yes |
| Abnormal Heart or Previous Bacterial Endocarditis | No | Yes | Unintentional Weight Loss/Gain | No | Yes |
| Heart Valve (artificial) or Heart Transplant | No | Yes | H.I.V. Infection/AIDS | No | Yes |
| Congenital Heart Disease | No | Yes | Venereal Disease | No | Yes |
| Heart Disease, Heart Attack, Heart Surgery | No | Yes | Recurrent Illnesses | No | Yes |
| Heart Stent? When placed? | No | Yes | Do you use tobacco? | No | Yes |

First Name Last Name MI

Sex □ M □F Date of Birth Age: **\* Social Security number**

MUST HAVE SOCIAL SECURITY NUMBER TO SUBMIT TO DENTAL/MEDICAL INSURANCE

Address City State ZIP Home Phone Cell Phone

Email

Marital Status (check one) □Minor □Single □Married □Divorced □Widowed □Separated

Employer Work Phone Employer Address City State Zip Emergency Contact Relationship Phone

# MUST BE UPDATED EACH YEAR WITH ALL INFORMATION

**DENTAL INSURANCE INFORMATION**

Insurance Holder’s Name Relationship to Insured □Self □Spouse □Child □Other Insurance Holder’s date of birth Insurance Holder’s social security number Insurance Company

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Member ID Group # Employer Insurance Company Address Insurance Company phone number

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If “YES”, for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

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| Glaucoma | No | Yes | Slow-Healing Mouth Sores | No | Yes |
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| Heart Disease, Heart Attack, Heart Surgery | No | Yes | Recurrent Illnesses | No | Yes |
| Heart Stent? When placed? | No | Yes | Do you use tobacco? | No | Yes |

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Please list any medications you are currently taking and dosages:

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Do you take a Pre-medication prior to dental appointments? NO YES

If “YES”, for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES If so, when did the treatment begin? When did the treatment end?

Are you currently taking any blood thinners? NO YES Which Drug:

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5. Latex or Metals No Yes
6. Other (please specify)

***For the following questions circle yes or no.***

|  |  |  |  |  |  |
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| Anemia or Blood Disorder? | No | Yes | Hepatitis, Any Form | No | Yes |
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| Cancer or Tumor? | No | Yes | Sore/Enlarged Lymph Nodes | No | Yes |
| Diabetes | No | Yes | High Blood Pressure | No | Yes |
| Emphysema or other Respiratory/Lung Illnesses | No | Yes | Low Blood Pressure | No | Yes |
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| Fainting or Dizzy Spells | No | Yes | Thyroid Disease | No | Yes |
| Glaucoma | No | Yes | Slow-Healing Mouth Sores | No | Yes |
| Abnormal Heart or Previous Bacterial Endocarditis | No | Yes | Unintentional Weight Loss/Gain | No | Yes |
| Heart Valve (artificial) or Heart Transplant | No | Yes | H.I.V. Infection/AIDS | No | Yes |
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| Heart Disease, Heart Attack, Heart Surgery | No | Yes | Recurrent Illnesses | No | Yes |
| Heart Stent? When placed? | No | Yes | Do you use tobacco? | No | Yes |

First Name Last Name MI

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Member ID Group # Employer Insurance Company Address Insurance Company phone number

Date of last medical exam: What was this exam for?

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: Are you currently under a physician’s care? No Yes If yes, nature of care: Please list all the names and phone numbers of the physicians who are currently providing you care:

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Do you take a Pre-medication prior to dental appointments? NO YES

If “YES”, for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES If so, when did the treatment begin? When did the treatment end?

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1. Local anesthetics No Yes
2. Penicillin No Yes
3. Aspirin, Ibuprofen or Tylenol No Yes
4. Codeine, Valium or sedatives No Yes
5. Latex or Metals No Yes
6. Other (please specify)

***For the following questions circle yes or no.***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Anemia or Blood Disorder? | No | Yes | Hepatitis, Any Form | No | Yes |
| Arthritis, Rheumatism or other inflammatory disease? | No | Yes | Joint Replacement? When placed? | No | Yes |
| Asthma | No | Yes | Kidney Disease | No | Yes |
| Abnormal Bleeding from a cut? | No | Yes | Liver Disease (including Jaundice) | No | Yes |
| Cancer or Tumor? | No | Yes | Sore/Enlarged Lymph Nodes | No | Yes |
| Diabetes | No | Yes | High Blood Pressure | No | Yes |
| Emphysema or other Respiratory/Lung Illnesses | No | Yes | Low Blood Pressure | No | Yes |
| Epilepsy | No | Yes | Radiation or Chemotherapy Treatment | No | Yes |
| Fainting or Dizzy Spells | No | Yes | Thyroid Disease | No | Yes |
| Glaucoma | No | Yes | Slow-Healing Mouth Sores | No | Yes |
| Abnormal Heart or Previous Bacterial Endocarditis | No | Yes | Unintentional Weight Loss/Gain | No | Yes |
| Heart Valve (artificial) or Heart Transplant | No | Yes | H.I.V. Infection/AIDS | No | Yes |
| Congenital Heart Disease | No | Yes | Venereal Disease | No | Yes |
| Heart Disease, Heart Attack, Heart Surgery | No | Yes | Recurrent Illnesses | No | Yes |
| Heart Stent? When placed? | No | Yes | Do you use tobacco? | No | Yes |

First Name Last Name MI

Sex □ M □F Date of Birth Age: **\* Social Security number**

MUST HAVE SOCIAL SECURITY NUMBER TO SUBMIT TO DENTAL/MEDICAL INSURANCE

Address City State ZIP Home Phone Cell Phone

Email

Marital Status (check one) □Minor □Single □Married □Divorced □Widowed □Separated

Employer Work Phone Employer Address City State Zip Emergency Contact Relationship Phone

# MUST BE UPDATED EACH YEAR WITH ALL INFORMATION

**DENTAL INSURANCE INFORMATION**

Insurance Holder’s Name Relationship to Insured □Self □Spouse □Child □Other Insurance Holder’s date of birth Insurance Holder’s social security number Insurance Company

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Member ID Group # Employer Insurance Company Address Insurance Company phone number

## *FEDERAL EMPLOYEE’S ONLY*

**MEDICAL INSURANCE INFORMATION**

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Date of last medical exam: What was this exam for?

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: Are you currently under a physician’s care? No Yes If yes, nature of care: Please list all the names and phone numbers of the physicians who are currently providing you care:

1.

2.

3.

Please list any medications you are currently taking and dosages:

1.

2.

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Do you take a Pre-medication prior to dental appointments? NO YES

If “YES”, for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES If so, when did the treatment begin? When did the treatment end?

Are you currently taking any blood thinners? NO YES Which Drug:

|  |  |  |
| --- | --- | --- |
| Women: Are you pregnant? | No | Yes |
| If no, are you planning a pregnancy in the near future? | No | Yes |
| Are you a nursing mother? | No | Yes |

Are you allergic or have you had a reaction to:

1. Local anesthetics No Yes
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| Diabetes | No | Yes | High Blood Pressure | No | Yes |
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| Glaucoma | No | Yes | Slow-Healing Mouth Sores | No | Yes |
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Please list any medications you are currently taking and dosages:

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Are you currently taking any blood thinners? NO YES Which Drug:

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| Heart Stent? When placed? | No | Yes | Do you use tobacco? | No | Yes |

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Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: Are you currently under a physician’s care? No Yes If yes, nature of care: Please list all the names and phone numbers of the physicians who are currently providing you care:

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2.

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Please list any medications you are currently taking and dosages:

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Do you take a Pre-medication prior to dental appointments? NO YES

If “YES”, for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES If so, when did the treatment begin? When did the treatment end?

Are you currently taking any blood thinners? NO YES Which Drug:

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| Women: Are you pregnant? | No | Yes |
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| Diabetes | No | Yes | High Blood Pressure | No | Yes |
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| Glaucoma | No | Yes | Slow-Healing Mouth Sores | No | Yes |
| Abnormal Heart or Previous Bacterial Endocarditis | No | Yes | Unintentional Weight Loss/Gain | No | Yes |
| Heart Valve (artificial) or Heart Transplant | No | Yes | H.I.V. Infection/AIDS | No | Yes |
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| Heart Disease, Heart Attack, Heart Surgery | No | Yes | Recurrent Illnesses | No | Yes |
| Heart Stent? When placed? | No | Yes | Do you use tobacco? | No | Yes |

First Name Last Name MI

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## *FEDERAL EMPLOYEE’S ONLY*

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Member ID Group # Employer Insurance Company Address Insurance Company phone number

Date of last medical exam: What was this exam for?

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: Are you currently under a physician’s care? No Yes If yes, nature of care: Please list all the names and phone numbers of the physicians who are currently providing you care:

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Please list any medications you are currently taking and dosages:

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Do you take a Pre-medication prior to dental appointments? NO YES

If “YES”, for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES If so, when did the treatment begin? When did the treatment end?

Are you currently taking any blood thinners? NO YES Which Drug:

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| Women: Are you pregnant? | No | Yes |
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| Diabetes | No | Yes | High Blood Pressure | No | Yes |
| Emphysema or other Respiratory/Lung Illnesses | No | Yes | Low Blood Pressure | No | Yes |
| Epilepsy | No | Yes | Radiation or Chemotherapy Treatment | No | Yes |
| Fainting or Dizzy Spells | No | Yes | Thyroid Disease | No | Yes |
| Glaucoma | No | Yes | Slow-Healing Mouth Sores | No | Yes |
| Abnormal Heart or Previous Bacterial Endocarditis | No | Yes | Unintentional Weight Loss/Gain | No | Yes |
| Heart Valve (artificial) or Heart Transplant | No | Yes | H.I.V. Infection/AIDS | No | Yes |
| Congenital Heart Disease | No | Yes | Venereal Disease | No | Yes |
| Heart Disease, Heart Attack, Heart Surgery | No | Yes | Recurrent Illnesses | No | Yes |
| Heart Stent? When placed? | No | Yes | Do you use tobacco? | No | Yes |

First Name Last Name MI

Sex □ M □F Date of Birth Age: **\* Social Security number**

MUST HAVE SOCIAL SECURITY NUMBER TO SUBMIT TO DENTAL/MEDICAL INSURANCE

Address City State ZIP Home Phone Cell Phone

Email

Marital Status (check one) □Minor □Single □Married □Divorced □Widowed □Separated

Employer Work Phone Employer Address City State Zip Emergency Contact Relationship Phone

# MUST BE UPDATED EACH YEAR WITH ALL INFORMATION

**DENTAL INSURANCE INFORMATION**

Insurance Holder’s Name Relationship to Insured □Self □Spouse □Child □Other Insurance Holder’s date of birth Insurance Holder’s social security number Insurance Company

\**The proceeding information will be on your dental insurance card.*

Member ID Group # Employer Insurance Company Address Insurance Company phone number

## *FEDERAL EMPLOYEE’S ONLY*

**MEDICAL INSURANCE INFORMATION**

Insurance Holder’s Name Relationship to Insured □Self □Spouse □Child □Other Insured’s holder date of birth Insurance Holder’s social security Insurance company

*\*The proceeding information will be on your medical card*

Member ID Group # Employer Insurance Company Address Insurance Company phone number

Date of last medical exam: What was this exam for?

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: Are you currently under a physician’s care? No Yes If yes, nature of care: Please list all the names and phone numbers of the physicians who are currently providing you care:

1.

2.

3.

Please list any medications you are currently taking and dosages:

1.

2.

3.

4.

Do you take a Pre-medication prior to dental appointments? NO YES

If “YES”, for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES If so, when did the treatment begin? When did the treatment end?

Are you currently taking any blood thinners? NO YES Which Drug:

|  |  |  |
| --- | --- | --- |
| Women: Are you pregnant? | No | Yes |
| If no, are you planning a pregnancy in the near future? | No | Yes |
| Are you a nursing mother? | No | Yes |

Are you allergic or have you had a reaction to:

1. Local anesthetics No Yes
2. Penicillin No Yes
3. Aspirin, Ibuprofen or Tylenol No Yes
4. Codeine, Valium or sedatives No Yes
5. Latex or Metals No Yes
6. Other (please specify)

***For the following questions circle yes or no.***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Anemia or Blood Disorder? | No | Yes | Hepatitis, Any Form | No | Yes |
| Arthritis, Rheumatism or other inflammatory disease? | No | Yes | Joint Replacement? When placed? | No | Yes |
| Asthma | No | Yes | Kidney Disease | No | Yes |
| Abnormal Bleeding from a cut? | No | Yes | Liver Disease (including Jaundice) | No | Yes |
| Cancer or Tumor? | No | Yes | Sore/Enlarged Lymph Nodes | No | Yes |
| Diabetes | No | Yes | High Blood Pressure | No | Yes |
| Emphysema or other Respiratory/Lung Illnesses | No | Yes | Low Blood Pressure | No | Yes |
| Epilepsy | No | Yes | Radiation or Chemotherapy Treatment | No | Yes |
| Fainting or Dizzy Spells | No | Yes | Thyroid Disease | No | Yes |
| Glaucoma | No | Yes | Slow-Healing Mouth Sores | No | Yes |
| Abnormal Heart or Previous Bacterial Endocarditis | No | Yes | Unintentional Weight Loss/Gain | No | Yes |
| Heart Valve (artificial) or Heart Transplant | No | Yes | H.I.V. Infection/AIDS | No | Yes |
| Congenital Heart Disease | No | Yes | Venereal Disease | No | Yes |
| Heart Disease, Heart Attack, Heart Surgery | No | Yes | Recurrent Illnesses | No | Yes |
| Heart Stent? When placed? | No | Yes | Do you use tobacco? | No | Yes |

First Name Last Name MI

Sex □ M □F Date of Birth Age: **\* Social Security number**

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**DENTAL INSURANCE INFORMATION**

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Member ID Group # Employer Insurance Company Address Insurance Company phone number

## *FEDERAL EMPLOYEE’S ONLY*

**MEDICAL INSURANCE INFORMATION**

Insurance Holder’s Name Relationship to Insured □Self □Spouse □Child □Other Insured’s holder date of birth Insurance Holder’s social security Insurance company

*\*The proceeding information will be on your medical card*

Member ID Group # Employer Insurance Company Address Insurance Company phone number

Date of last medical exam: What was this exam for?

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: Are you currently under a physician’s care? No Yes If yes, nature of care: Please list all the names and phone numbers of the physicians who are currently providing you care:

1.

2.

3.

Please list any medications you are currently taking and dosages:

1.

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4.

Do you take a Pre-medication prior to dental appointments? NO YES

If “YES”, for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES If so, when did the treatment begin? When did the treatment end?

Are you currently taking any blood thinners? NO YES Which Drug:

|  |  |  |
| --- | --- | --- |
| Women: Are you pregnant? | No | Yes |
| If no, are you planning a pregnancy in the near future? | No | Yes |
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Are you allergic or have you had a reaction to:

1. Local anesthetics No Yes
2. Penicillin No Yes
3. Aspirin, Ibuprofen or Tylenol No Yes
4. Codeine, Valium or sedatives No Yes
5. Latex or Metals No Yes
6. Other (please specify)

***For the following questions circle yes or no.***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Anemia or Blood Disorder? | No | Yes | Hepatitis, Any Form | No | Yes |
| Arthritis, Rheumatism or other inflammatory disease? | No | Yes | Joint Replacement? When placed? | No | Yes |
| Asthma | No | Yes | Kidney Disease | No | Yes |
| Abnormal Bleeding from a cut? | No | Yes | Liver Disease (including Jaundice) | No | Yes |
| Cancer or Tumor? | No | Yes | Sore/Enlarged Lymph Nodes | No | Yes |
| Diabetes | No | Yes | High Blood Pressure | No | Yes |
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| Fainting or Dizzy Spells | No | Yes | Thyroid Disease | No | Yes |
| Glaucoma | No | Yes | Slow-Healing Mouth Sores | No | Yes |
| Abnormal Heart or Previous Bacterial Endocarditis | No | Yes | Unintentional Weight Loss/Gain | No | Yes |
| Heart Valve (artificial) or Heart Transplant | No | Yes | H.I.V. Infection/AIDS | No | Yes |
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| Heart Stent? When placed? | No | Yes | Do you use tobacco? | No | Yes |

First Name Last Name MI

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**DENTAL INSURANCE INFORMATION**

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## *FEDERAL EMPLOYEE’S ONLY*

**MEDICAL INSURANCE INFORMATION**

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Member ID Group # Employer Insurance Company Address Insurance Company phone number

Date of last medical exam: What was this exam for?

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: Are you currently under a physician’s care? No Yes If yes, nature of care: Please list all the names and phone numbers of the physicians who are currently providing you care:

1.

2.

3.

Please list any medications you are currently taking and dosages:

1.

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Do you take a Pre-medication prior to dental appointments? NO YES

If “YES”, for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

Are you being or have you ever been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)? NO YES If so, when did the treatment begin? When did the treatment end?

Are you currently taking any blood thinners? NO YES Which Drug:

|  |  |  |
| --- | --- | --- |
| Women: Are you pregnant? | No | Yes |
| If no, are you planning a pregnancy in the near future? | No | Yes |
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Are you allergic or have you had a reaction to:

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6. Other (please specify)

***For the following questions circle yes or no.***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Anemia or Blood Disorder? | No | Yes | Hepatitis, Any Form | No | Yes |
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| Asthma | No | Yes | Kidney Disease | No | Yes |
| Abnormal Bleeding from a cut? | No | Yes | Liver Disease (including Jaundice) | No | Yes |
| Cancer or Tumor? | No | Yes | Sore/Enlarged Lymph Nodes | No | Yes |
| Diabetes | No | Yes | High Blood Pressure | No | Yes |
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Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: Are you currently under a physician’s care? No Yes If yes, nature of care: Please list all the names and phone numbers of the physicians who are currently providing you care:

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Please list any medications you are currently taking and dosages:

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Member ID Group # Employer Insurance Company Address Insurance Company phone number

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Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: Are you currently under a physician’s care? No Yes If yes, nature of care: Please list all the names and phone numbers of the physicians who are currently providing you care:

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Do you take a Pre-medication prior to dental appointments? NO YES

If “YES”, for what reason? Heart Condition (Valve replacement/murmur/transplant) Joint Replacement (knee/hip)

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