Greenlee dental center

1018 Oberlin Road
Raleigh, NC 27605
919.833.4634

Today's Date:_____

Patient

Name:_____ DOB:_____ Social Security#:_____

Address:_____ZIP_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email:_____ Employer:_____

Position:_____ If patient is a minor, parent or guardian's name:_____

Is another family member a patient here? Y N Name:_____

Whom may we thank for referring you to our office? _____

Parent / Spouse

Name:_____ DOB:_____ Relationship to Patient:_____

Address:_____ZIP_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Employer:_____ Position:_____

Dental Insurance

Primary Insurance Company:_____

Insurance Company Address: _____ZIP_____

Insurance provided through which Employer? _____ If not your employer,

Family Member's name:_____ Relation to patient:_____

Member#:_____ Group#:_____

Do you have dual coverage? Y N **Secondary** Insurance Company:_____

Insurance Company Address: _____ZIP_____

Insurance provided through which Employer? _____ If not your employer,

Family Member's name:_____ Relation to patient:_____

Member#:_____ Group#:_____

Emergency Contact

Name of nearest relative **NOT** living with you:_____

Address:_____ZIP_____

Phone:_____

Preferred Pharmacy

Name: _____ Address:_____

_____ZIP_____ Phone:_____

Medical History:

1. Are you taking any drug or medicine? Yes No
   If yes, what? _____
2. Are you allergic or have you reacted adversely to any drugs or medicines
   If yes, what? _____ Yes No
3. Have you ever had any serious problem with dental treatment? Yes No
4. Have you ever had abnormal bleeding associated with previous extractions?
   Surgery or trauma? Yes No
5. Do you use tobacco products? Yes No
   If yes, what and how much per day? _____
6. Are you under the care of a physician? _____ Yes No
   If yes, what is the condition being treated?_____
7. Physician's Name_____Phone #_____
   Address_____
8. Have you had any serious illness and/or hospitalization in the last 5 years? Yes No
   If yes, please describe briefly_____
9. Are you taking, or have you ever taken bisphosphonates such as Fosamax,
   Boniva, Actonel, Atelvia, Reclast? Yes No
10. Do you currently have or have you had any of the following diseases or problems?
    (PLEASE CIRCLE.)

Heart failure	Emphysema	Diabetes
Heart disease or Attack	Tuberculosis	Thyroid Disease
Angina Pectoris	Asthma	X-ray or Cobalt Treatment
High Blood Pressure	Hay Fever	Chemotherapy (Cancer, Leukemia)
Heart Murmur	Sinus Trouble	Arthritis
Mitral Valve Prolapse	Allergies/Hives	Rheumatism
Rheumatic Fever	Artificial Joint	Glaucoma
Artificial Heart Valve	Anemia	Pain in Jaw Joints
Heart Pacemaker	Stroke	Fainting or Dizzy Spells
Heart Surgery	Kidney Trouble	Epilepsy or Seizures
HIV or AIDS	Ulcers	Cold Sores
Hepatitis A,B,C	Sickle Cell Disease	STD or VD
Liver Disease	Psychiatric Treatment	Blood Transfusion
Yellow Jaundice	Nervousness/Anxiety	

Women Only:

Are you Pregnant? Yes No
If yes, what month?.....
Are you taking birth control pills or hormonal therapy? Yes No

To the best of my knowledge the preceding answers are true and correct. If I have any changes in my health or in my medications, I will inform Dr. Greenlee at my next appointment.

Patient signature_____ Date_____