HOW DID YOU HEAR ABOUT US?

○ GOOGLE ○ DRIVE BY ○ FACEBOOK ○ WEBSITE
○ EXISTING PT ○ ANOTHER OFFICE ○ INS DIRECTORY
○ SIGN ○ OTHER____________________

DR. NATHAN BOWEN
5469 S STATE HWY FF
BATTLEFIELD, MO 65619
417-447-5180

PATIENT INFORMATION

DATE__________________	
NAME________________________________	DOB______________ SSN_______-_______-______
ADDRESS________________________________	HOME PHONE________________________________
________________________________	CELL PHONE________________________________
PLACE OF EMPLOYMENT________________________	EMAIL ________________________________
DENTAL INS CARRIER________________________	EMERG CONTACT NAME__________________#__________________

Although dental personnel treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking could have an important interrelationship with the dentistry you receive. Thank you for answering the following questions to the best of your knowledge.

Question	Yes	No	Details
Are you under a physician's care	○ yes	○ no	If yes, please explain
Have you ever been hospitalized or had a major surgery	○ yes	○ no	If yes, please note
Have you ever had a serious head or neck injury	○ yes	○ no	If yes, please note
Are you taking any medications, pills, or drugs	○ yes	○ no	If yes, please list ________________________________ ________________________________ ________________________________
Do you have any artificial joints	○ yes	○ no	If yes, list joint and month/year of replacement
Are you or have you taken a osteoporosis medication (Fosamax, Boniva, Pirlo, Actonel)	○ yes	○ no	If yes, please list
Are you on a special diet	○ yes	○ no	
Do you use tobacco	○ yes	○ no	
Do you use a controlled substances	○ yes	○ no	

Women Only: Pregnant/Trying ○ yes ○ no Nursing ○ yes ○ no Taking Birth Control ○ yes ○ no

ARE YOU ALLERGIC TO ANY TO THE FOLLOWING: ○ Penicillin ○ Sulfa Drugs ○ Aspirin ○ Codeine ○ Anesthetics ○ Metal ○ Latex ○ Acrylic ○ Other________________________________

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING

○ AID/HIV POSITIVE	○ CORTISONE MEDIICINE	○ HEMOPHILIA	○ RADIATION TREATMENT
○ ALZHEIMER'S	○ DIABETES	○ HEPATITIS A	○ RECENT WEIGHT LOSS
○ ANAPHYLAXIS	○ DRUG ADDICTION	○ HEPATITIS B OR C	○ RENAL DIALYSIS
○ ANEMIA	○ EASILY WINDED	○ HERPES	○ RHEUMATIC FEVER
○ ANGINA	○ EMPHYSEMA	○ HIGH BLOOD PRESSURE	○ SCARLET FEVER
○ ARTHRITIS/GOUT	○ EPILEPSY/SEIZURES	○ HIGH CHOLESTEROL	○ SHINGLES
○ ARTIFICIAL HEART VALVE	○ EXCESS BLEEDING	○ HIVES/RASH	○ SICKLE CELL DISEASE
○ ARTIFICIAL JOINT	○ EXCESS THIRST	○ HYPOGLYCEMIA	○ SINUS TROUBLE
○ ASTHMA	○ FAINTING/DIZZY SPELLS	○ IRREGULAR HEARTBEAT	○ SPINA BIFIDA
○ BLOOD DISEASE	○ FREQUENT COUGH	○ KIDNEY ISSUES	○ STOMACH/INTESTINE DISEASE
○ BLOOD TRANSFUSION	○ FREQUENT DIARRHEA	○ LEUKEMIA	○ STROKE
○ BREATHING PROBLEM	○ FREQUENT HEADACHES	○ LIVER DISEASE	○ SWELLING OF LIMBS
○ BRUISE EASILY	○ GENITAL HERPES	○ LOW BLOOD PRESSURE	○ THYROID DISEASE
○ CANCER	○ GLAUCOMA	○ LUNG DISEASE	○ TONSILITIS
○ CHEMOTHERAPY	○ HAY FEVER	○ MITRAL VALVE PROLAPSE	○ TUBERCULOSIS
○ CHEST PAINS	○ HEART ATTACK/FAILURE	○ OSTEOPOROSIS	○ TUMORS OR GROWTH
○ COLD SORES/ FEVER BLISTERS	○ HEART MURMUR	○ PAIN IN JAW	○ ULCERS
○ CONGENITAL HEAR DISORDER	○ HEART PACEMAKER	○ PARATHYROID DISEASE	○ VENEREAL DISEASE
○ CONVULSIONS	○ HEART DISEASE	○ PSYCHIATRIC CARE	○ YELLOW JAUNDICE

ANY OTHER SERIOUS ILLNESS NOT LISTED:

TO THE BEST OF MY KNOWLEDGE THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

PATIENT/LEGAL GUARDIAN____ DATE________________________