Dr. Stephen Shanahan

CONFIDENTIAL **NEW PATIENT FORM**

Name:_____ M / F
Address:_____
Cell Phone: _____ Email: _____
Home Phone: _____ Work Phone: _____
Birthdate: _____ If child, name of parent: _____

Insurance: (Y / N) Employer: _____
Insurance Company: _____Group No.:_____Certificate No.:_____
Secondary Insurance: (Y / N) Employer: _____
Insurance Company: _____Group No.:_____Certificate No.:_____
Referred by: _____

MEDICAL HISTORY

1. Do you have any allergies? If yes, please specify: _____
2. Are you allergic to any specific medication? If so, please list: _____
3. Are you taking any medication now? If yes, please list (or provide a list from your pharmacy):

_____

4. Have you ever had rheumatic fever? YES NO
5. Do you have any artificial joints? YES NO
6. Do you have any prosthetic heart valves? YES NO
7. (Women only)Are you pregnant? YES NO
8. Do you have osteoporosis? YES NO What medication are you taking? _____
9. Do you have a serious illness now? Please specify: _____
10. Have you had a serious illness in the past? Please specify: _____
11. Have you ever had hepatitis A / B / C / HIV ? YES NO
12. Are you a smoker? YES NO
13. Approximately when was your last visit to the dentist? _____
14. Any specific dental problem you would like to discuss today? _____
15. Pharmacy Name and Telephone: _____
16. Medical Doctor Name and Telephone: _____
17. In case of emergency, notify: _____ Tel: _____

Signature of patient: _____ Date:_____
or parent if child under 18

MEDICAL HISTORY UPDATE

Date	Same	Change	Date	Same	Change
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____