Sher Himmat S. Gill D.D.S.

Patient Information

Patient Name:_____S.S.#_____-_____-_____Date:_____/_____/_____
First Middle Initial Last

Address:_____City:_____ State:_____ Zip:_____

Sex: ☐Male ☐Female Birthdate:_____/_____/_____ ☐Married ☐Widowed ☐Single ☐Minor ☐Divorced

Home Phone:( )_____ Cell Phone:( ) _____Work Phone:( )_____Email:_____

Patient Employer:_____Occupation:_____

Spouse/Parent's Name:_____Employer:_____Work Phone:( )_____

Emergency Contact:_____Phone:( )_____Relationship:_____

Medical History

Physician:_____Phone:( )_____

Please list **all** medications you are currently taking:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Drug Allergies:_____

Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth control pills? ☐Yes ☐No

Check box if you have had any of the following:

☐ AIDS
☐ Anemia
☐ Arthritis
☐ Artificial Heart Valve
☐ Artificial Joints
☐ Asthma
☐ Bleeding Abnormally
☐ Blood Disease
☐ Cancer
☐ Chemical Dependency
☐ Chemotherapy
☐ Circulatory Problems
☐ Congenital Heart Lesions
☐ Cortisone Treatments
☐ Cough, Persistent
☐ Cough Up Blood
☐ Diabetes
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
Describe_____
_____
☐ Hemophilia
☐ Hepatitis
☐ Hernia Repair
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV Positive
☐ Jaw Pain
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Nervous Problems
☐ Pacemaker
☐ Psychiatric Care
☐ Radiation Therapy
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Shortness of Breath
☐ Skin Rash
☐ Stroke
☐ Swelling of Feet or Ankles
☐ Thyroid Problems
☐ Tobacco Habit
☐ Tonsilitis
☐ Tuberculosis

Have you ever taken any of these medications?

Bisphosphonates: ☐ alendronate (Fosamax) ☐ ibandronate (Boniva) ☐ risedronate (Actonel) ☐ zoledronic acid (Reclast)
Blood Thinners: ☐ Coumadin ☐ Warfarin
Other: ☐ Levoxyl ☐ Synthroid

Dental Insurance? ☐Yes ☐No

Insurance Information

Insurance Co.:_____Policy or ID#_____Group#:_____

Name of Insured:_____S.S.#_____-_____-_____Relationship to Patient:_____

Birthdate of Insured:_____/_____/_____ Employer:_____Phone:( )_____

See Reverse ➔