Jonathan Foshay, DMD, PC

Name_____ Birthdate_____

Mailing Address _____

Physical Address (if different) _____ Social Security # _____

Primary Phone _____ Home/Cell Phone _____ Spouse Phone _____

Employer _____ Work Phone _____

*Spouse/Parent_____Birthdate_____ Marital Status: M S D

Spouse Employer _____ Work Phone _____

* Dental Insurance Co. _____ Phone#_____

ID #_____ Group # _____

Name of Subscriber _____ Birthdate _____

Subscribers Social Security # _____ Primary Phone _____

(if you have secondary please use back of form)

Medical History

Physicians Name _____ Phone _____ Date of last visit_____

Have you had any serious illnesses or operations? Y/N if yes type/date_____

Have you had a blood transfusion? Y/N if yes, approximate date _____

(Women) Are you pregnant? Y/N Nursing? Y/N Taking birth control? Y/N

Circle if you have / had any of the following:

Anemia	Cough, persistent	HIV/ AIDS	Skin Rash
Arthritis, Rheumatism	Cough up Blood	Jaw Pain	Stroke
Artificial Joints	Diabetes	Kidney Disease	Swelling of Feet or Ankles
Artificial Heart Valves	Epilepsy	Liver Disease	Thyroid Problems
Asthma	Fainting	MRSA	Tobacco Habit
Back Problems	Glaucoma	Mitral Valve Prolapse	Tonsillitis
Blood Disease	Headaches	Pacemaker	Tuberculosis
Cancer	Heart Murmur	Radiation Treatment	Ulcer
Chemical Dependency	Heart Problems	Respiratory Disease	Venereal Disease
Chemotherapy	Hemophilia	Rheumatic Fever	
Circulatory Problems	Hepatitis	Scarlet Fever	
Cortisone Treatment	High Blood Pressure	Shortness of Breath	

Medications

_____

_____

Allergies

_____

_____

Signature_____ Date _____