Dr. Marshall Baldassarre, D.M.D 404 Riverway Place, Blg #4 Bedford, NH 03110 603-624-8042

Patient Information

Date: ___________________

Patient Name: ____ Date of Birth: _______________

Patient Address: ____ State:______ Zip code:_______________

Patient Home Phone Number: _____-______-________ Patient Cell Phone Number: _____-_____-_______

Patient Social Security Number: ______-______-_______ Sex: ____ Email: ____

Are you a full time Student? Yes: ____ No: ____ Marital Status: __________________________

Employer: ____

Street Address: ____ State: _____ Zip Code: __________

Insurance Information:

1. ***Dental Insurance Carrier****:* ____ Phone Number: ____-_______-_______

Address: ____ State: _____ Zip Code: ________

Patient ID#:____ Group #:__________________________

Subscriber Name: ____ Subscriber Date of Birth: ________________

2***. Medical Insurance Carrier:*** ____ Phone Number: _____-_______-_______

Address: ____ State: _____ Zip Code: ________

Patient ID#:____ Group #:__________________________

Subscriber Name: ____ Subscriber Date of Birth: ________________

3***. Additional Insurance Carrier:*** ____ Phone Number: _____-_______-_______

Address: ____ State: _____ Zip Code: ________

Patient ID#:____ Group #:__________________________

Guarantor Information:

Party Responsible for Patients Bill if other than self:____

Relation to patient: ____________________________ Date of Birth: ____-____-_____ Phone Number: _____-_____-_______.

Street Address: ____ Town: _____________________ State: ________ Zip Code: ________

Patient Name: ____ **Date of Birth**: __________________________ Age:________

Has the patient ever had any of the following medical conditions?

	Yes	No
Rheumatic Fever:	______	______
Heart Murmur:	______	______
Heart Trouble:	______	______
Heart Valve Replacement:	______	______
High Blood pressure:	______	______
Coronary Bypass:	______	______
Bleeding Problems:	______	______
Immune Deficiency:	______	______
Hip or Knee Replacement:	______	______
Epilepsy/ Seizures:	______	______
Kidney Disease:	______	______
Diabetes:	______	______
Hepatitis or Liver Disease:	______	______
Arthritis:	______	______
TMJ Problems or Pain:	______	______

	Yes	No
Sinus or Nasal Problems:	_______	_______
Lung Trouble:	_______	_______
Asthma:	_______	_______
Tuberculosis:	_______	_______
Fainting spells:	_______	_______
Anemia:	_______	_______

Are you taking or have you ever taken Bisphosphonates (Fosamax or Actonel for Osteoporosis, or Chemotherapy for multiple myeloma, ect.) ____________________________ Y N

Do you have or ever had cancer ____________________ Y N

Radiation (X-Ray) treatment for Cancer? _____________ Y N

General Anesthesia _________________________ When?_________________ What ?___________________

Have you ever been Hospitalized? When? _________________ Why?____

Have you had any serious illness or injuries? ____

____

Have you ever been under a physician's care within the past five years? Yes__________ No____________

If so why? ____

Do you have any other disease, condition or problem not listed that you think the doctor should know about? Yes______ No______

If so what?____

			List Medications:
Are you in good health?:	Yes ____	No____	
Are you taking birth control pills?:	Yes ____	No____	______________________________
Are you pregnant?:	Yes ____	No____	______________________________
Have you ever taken steroids or prednisone?:	Yes ____	No____	______________________________
Do you smoke/chew tobacco?:	Yes ____	No____	______________________________
Do you have a cold or Bronchitis?:	Yes ____	No____	______________________________
Are you allergic to Penicillin?:	Yes ____	No ____	______________________________
Other allergies?:	Yes ____	No ____	______________________________

Note: Patients taking birth control pills who are prescribed antibiotics should use another method of birth control for the remainder of the cycle. **Initial:** _________

Dentist_________________________ City___________________ State________ Phone #_____________________________

Physician________________________City___________________State________Phone #______________________________

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Health History with the doctor.

___________________ ____

Date Signature