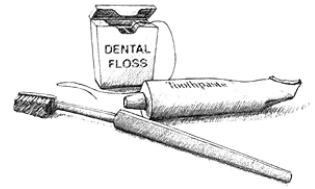


# THOMAS P. COSGROVE DMD, PC



## Patient information (Confidential)

Name \_\_\_\_\_  
Last Name      First Name      Middle Initial      Preferred Name

Address \_\_\_\_\_  
NO P O BOX ACCEPTED      City      St      Zip

Sex: M  F     Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_    Age \_\_\_\_    Single     Married     Divorced     Minor

Employed By \_\_\_\_\_    Occupation \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_    Driver License Number \_\_\_\_\_    State \_\_\_\_\_

Email Address \_\_\_\_\_@\_\_\_\_\_.com

*Please check which phone number is best to contact you*

Home (\_\_\_\_\_) \_\_\_\_\_     Work (\_\_\_\_\_) \_\_\_\_\_     Cell (\_\_\_\_\_) \_\_\_\_\_

If Student, Name of School \_\_\_\_\_    Full Time     or Part Time

Spouse/ Parent Name \_\_\_\_\_    Phone Number (\_\_\_\_\_) \_\_\_\_\_

In case of an emergency, who should be notified? \_\_\_\_\_    Phone Number (\_\_\_\_\_) \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

## INSURANCE INFORMATION

Name of Insured \_\_\_\_\_    Employer \_\_\_\_\_    Relation to patient \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_    SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_    Work Number (\_\_\_\_\_) \_\_\_\_\_

Insurance Company \_\_\_\_\_    Group # \_\_\_\_\_    ID # \_\_\_\_\_

## MEDICAL HISTORY

Physician Name \_\_\_\_\_    Date of last physical \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please list any DRUG ALLERGIES** \_\_\_\_\_

Are you under Medical Treatment right now? If so, for what? \_\_\_\_\_

Please list all medications that you are currently taking including prescription and over the counter medications: \_\_\_\_\_

Please check any Illnesses that apply and list medication taking for	
<input type="checkbox"/> <b>Mitral Valve Prolapse (MVP):</b>	<input type="checkbox"/> Tuberculosis:
<input type="checkbox"/> <b>Heart Murmur:</b>	<input type="checkbox"/> Cancer:
<input type="checkbox"/> <b>Rheumatic Fever:</b>	<input type="checkbox"/> Psychiatric Care:
<input type="checkbox"/> <b>Artificial Joints:</b>	<input type="checkbox"/> Headaches:
<input type="checkbox"/> <b>Heart Disease/ Problems:</b>	<input type="checkbox"/> Epilepsy:
<input type="checkbox"/> <b>AIDS or HIV Positive:</b>	<input type="checkbox"/> Diabetes:
<input type="checkbox"/> Dizziness/ Fainting:	<input type="checkbox"/> Hepatitis:
<input type="checkbox"/> Latex Allergy:	<input type="checkbox"/> Heart Stint:
<input type="checkbox"/> Cardiac Pacemaker:	<input type="checkbox"/> Smoker/ Lung Disease: please circle one
<input type="checkbox"/> High/ Low Blood Pressure: please circle one	<input type="checkbox"/> Arthritis:
<input type="checkbox"/> Circulatory Problems:	<input type="checkbox"/> Blood Transfusion/ Disease:
<input type="checkbox"/> Stroke/ Heart Attack: please circle one	<input type="checkbox"/> Ulcer:
<input type="checkbox"/> Immunosuppressive Disorder:	<input type="checkbox"/> Liver Disease:

Please list any hospitalizations \_\_\_\_\_

Are you under medical treatment now? \_\_\_\_\_

Are you currently on birth control? \_\_\_\_\_ Yes \_\_\_\_\_ No    Birth Control: \_\_\_\_\_  
(Some antibiotics may alter the effectiveness of birth control pills)

The above information is accurate and complete to the best of my knowledge and is only for us in my treatment and billing. I will not hold my dentist or any of his staff responsible for any errors or omissions that I may have made in the completion of this form. I consent to the performance of procedures, operations, and administration of anesthetics or any other medication considered to be necessary or advisable by the dentist.

Signature of responsible party \_\_\_\_\_    Date \_\_\_\_\_