BRICKYARD DENTAL GROUP

MICHAEL BARNO, DMD
CHRIS ROBNETT, DMD
NICOLE ANDREINI, DDS, MS

ANNUAL UPDATE

Patient's Name _____ **Date of Birth** _____

Address _____ **City** _____ **State** _____ **Zip Code** _____

Employer _____

Name of current dental insurance company _____

Circle one Single Married Other _____ **FOR WOMEN ONLY:** Are you pregnant? _____

Name of physician and date of last appointment _____

Please list ALL medications: (*use back of page if needed*) **Dosage**: **For treatment of**:

_____

_____

_____

Have you been hospitalized in the last year? *(if yes, explain)* _____

- **Are you now or have you ever taken medication for Osteoporosis?** (Oral or Injection) Yes _____ No _____

(e.g.: Boniva, Fosamax, Aredia, Reclast, etc) Taken from _____ to _____

- **Have you EVER had a joint replacement**? Type and year? _____ Orthopedist _____

If yes, what pre-med antibiotic do you take? _____

- **Have you ever had an allergic or adverse reaction to**: *(Please circle if yes)*

Local Anesthetics *(Novocain)* Codeine Penicillin Aspirin Latex Other _____

- **Please circle any you now or have ever had**: Diabetes High Blood Pressure Low Blood Pressure Ulcers

AIDS HIV+ Bleeding Problems GERD/Reflux Heart Disease Heart Murmur Hepatitis

Kidney Trouble Respiratory Problems Stroke Cancer (*type* _____) Chemotherapy Radiation

Other - Please explain: _____

_____

How may we contact you? HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ EMAIL _____

WE FILE YOUR INSURANCE AS A COURTESY. YOUR ESTIMATED PORTION IS DUE WHEN SERVICES ARE RENEDERED.

_____ _____

Patient/Guardian Signature **Date**

122 N. BRICKYARD ROAD COLUMBIA, SC 29203 | 803.736.1024 BRICKYARDDENTALGROUP.COM