DR PAMELA J ASSEFF, DDS, PSC

PATIENT NAME _____ DATE OF BIRTH_____

- Has your address changed since your last visit? Yes or No (Please circle)
- Has your **DENTAL** insurance changed since your last visit? Yes or No (Please circle)
- Please give us the **BEST** phone number to contact you:_____
- Please give preferred email address:_____
- Do you prefer **TEXT** (cell phone provider:_____, **PHONE CALL** or **E-MAIL** for your appointment reminders?(Please circle)
- List any **Current Medications** you are taking (include both prescription and over the counter);_____
  _____
- Do you have any allergies or adverse reactions to any medications or Latex? Yes or No(Please circle) If Yes Please list_____
- Have you had a joint replacement? Yes of No(Please circle) If Yes, please list type and date of placement_____
- Have you had any Major Health Issues, Surgeries or Hospitalizations since your last dental visit? Yes or No(Please circle)_____
  _____
- Have you ever taken bisphosphonates, antiresorptive or antiangiogenic drugs?(Medication that effects bone growth or metabolism) Yes or No(Please circle) If yes please list
  _____
- Please list your preferred pharmacy and phone:_____

Patient or Guardian Signature_____Date_____

Doctor or Hygienist Signature_____Date_____