

PATIENT INFORMATION

P A T I E N T	Dr. Mr. Mrs. Miss Ms.	PATIENT LAST NAME FIRST NAME MI. DATE OF BIRTH				
	MAILING ADDRESS		STREET	CITY	STATE	ZIP
	STREET ADDRESS (IF DIFFERENT)		STREET	CITY	STATE	ZIP
	OCCUPATION	EMPLOYER	EMPLOYER'S ADDRESS		BUSINESS PHONE #	
	PATIENT'S SOCIAL SECURITY #		SPOUSE'S NAME		HOME PHONE #	
	NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU			RELATIONSHIP		PHONE #
	GENERAL DENTIST			REFERRED BY (IF DIFFERENT)		
I N S U R A N C E	COMPLETE THIS SECTION IF YOU HAVE DENTAL INSURANCE AND PRESENT INSURANCE CARD TO RECEPTIONIST					
	Insurance Company Name		Policyholder (Subscriber)		Group #	
	1. _____	_____	_____		_____	
	Address		DOB of Subscriber		Employer	
R E S P O N S I B L E	Dr. Mr. Mrs. Miss Ms.	COMPLETE THIS SECTION ONLY IF RESPONSIBLE PARTY IS DIFFERENT THAN PATIENT				
	LAST NAME		FIRST NAME	MI.	RELATIONSHIP TO PATIENT	
	MAILING ADDRESS		STREET	CITY	STATE	ZIP
	HOME PHONE #		BUSINESS PHONE #		OCCUPATION	
	EMPLOYER			EMPLOYER'S ADDRESS		
P A Y M E N T	I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. Insurance policies vary greatly in type and extent. Dental insurance is a separate contract between you and the insurance company. Any financial benefits or partial benefits that you may receive is solely between you and the insurance company. Usual, customary and reasonable fees vary widely between insurance providers. YOU, THE PATIENT, SHOULD CLEARLY UNDERSTAND THAT COMPLETE PAYMENT FOR SERVICES RENDERED IS YOUR PERSONAL RESPONSIBILITY, REGARDLESS OF THE AMOUNT OF REIMBURSEMENT YOU RECEIVE FROM YOUR INSURANCE CARRIER. PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.					
	Preferred method of payment: <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Credit Card (MasterCard/Visa/Discover/American Express)					
DATE		SIGNATURE OF PATIENT, PARENT, GUARDIAN OR RESPONSIBLE PARTY				

COMPLETE REVERSE SIDE

PATIENT HEALTH HISTORY

Patient Name: _____

Physician's Name,
Address, & Phone Number: _____

Are you in good health? Yes No Last Medical Exam _____

Place a check (✓) beside any of the following which you have had or do have now:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Heart trouble/Disease | <input type="checkbox"/> Fainting spell | <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Lung/Breathing trouble |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Psychiatric treatment |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Radiation therapy |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fever Blisters/Herpes | <input type="checkbox"/> Prosthetic/Artificial joint(s) |
| <input type="checkbox"/> Damaged/Artificial heart valves | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> HIV+, AIDS, or ARC | <input type="checkbox"/> Hiatal hernia |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Addiction (alcohol, drugs, etc.) |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver trouble | <input type="checkbox"/> Kidney trouble | |

Other Diseases or Illnesses: _____

Allergies to: Local Anesthetic Yes No Penicillin Yes No Aspirin Yes No

Codeine Yes No Latex Yes No

Other Allergies: _____

Are you taking any of the following? If yes, please list

<u>MEDICATION</u>	<u>DOSAGE (mg & # /day)</u>	<u>MEDICATION</u>	<u>DOSAGE (mg & # /day)</u>
Antibiotics	<input type="checkbox"/> Yes _____	Antihistamines	<input type="checkbox"/> Yes _____
Dental Premedication	<input type="checkbox"/> Yes _____	Aspirin	<input type="checkbox"/> Yes _____
Anticoagulants (blood thinners)	<input type="checkbox"/> Yes _____	Tylenol	<input type="checkbox"/> Yes _____
High blood pressure medicine	<input type="checkbox"/> Yes _____	Insulin	<input type="checkbox"/> Yes _____
Cortisone (steroids)	<input type="checkbox"/> Yes _____	Nitroglycerin	<input type="checkbox"/> Yes _____
Sedatives/Tranquilizers	<input type="checkbox"/> Yes _____	Oral contraceptive	<input type="checkbox"/> Yes _____
Anti-inflammatories/NSAIDS	<input type="checkbox"/> Yes _____		

Other Medications Yes No _____

(Females) Are you pregnant? Yes No Number of Months: _____ Nursing? Yes No

Is there any other information about your health we should know? Yes No

Please explain: _____

Consent — Please read and sign:

I, the undersigned, affirm that the information above is accurate and complete to the best of my knowledge. I will not hold my endodontist or any member of the office staff responsible for errors or omissions that I have made in the completion of this form. I consent to any advisable and necessary endodontic therapy to be administered by the endodontist or his supervised staff for diagnostic purposes or dental treatment. I realize that treatment is no guarantee of success and factors such as post-treatment inflammation, infection and tooth fracture may complicate the prognosis.

I understand that I am to return to my dentist for permanent restoration of the treated tooth.

Patient (Parent/guardian) _____
SIGNATURE DATE

COMPLETE REVERSE SIDE