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Practice Limited to Endodontics
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Mr.__ Mrs.__ Ms. __ Dr. __ Date:_____-_____-_____

NAME:_____

Date of Birth _____-_____-____ Patients SS# _____-_____-_____

Address _____ _____ _____
Street Town Zip

Home #_____Cell# _____Work#_____

E-Mail Address _____

Name of your General Dentist _____

Person Financially Responsible for Treatment _____

In the unlikely event of an emergency, is there someone we should contact?

Name:_____Phone#_____Relationship_____

Primary Dental Coverage	*If you have Secondary Dental Coverage*
_____	_____
Name of Primary Insured Person	Name of Secondary Insured Person
Date of Birth ___/___/____	Date of Birth ___/___/____
_____	_____
Employer	Employer
_____	_____
Insurance Carrier	Insurance Carrier
Policy # _____	Policy #_____
Group # _____	Group #_____
SS# or ID#_____	SS# or ID#_____

DATE OF LAST PHYSICAL EXAMINATION_____

WHAT IS YOUR PRESENT HEALTH STATUS_____

DO YOU HAVE, OR HAVE YOU EVER HAD:

AIDS_____ ANEMIA_____ ASTHMA_____CANCER_____

DIABETES_____EPILEPSY_____GLAUCOMA_____HEPATITIS____

(JAUNDICE)_____KIDNEY PROBLEMS_____

RHEUMATIC FEVER_____THYROID PROBLEMS_____ULCERS_____

ABNORMAL BLEEDING FROM A CUT_____

ARTIFICIAL JOINT REPLACEMENT?_____
DO YOU NEED TO PREMEDICATE?_____

ARE YOU TAKING ANY BIPHOSPHONATES?_____
(i.e. Fasomax, Boniva, Aredia, Zometa, etc)?

ALLERGIES: PENICILLIN, OR ANY OTHER ANTIBIOTICS OR DRUGS, OR LOCAL ANESTHETIC (NOVACAINE)

ABNORMAL HEART CONDITION_____PACEMAKER_____

ARTIFICAL VALVES_____HEART MURMUR_____

MITRAL VALVE PROLAPSE_____DO YOU NEED TO PRE MEDICATE?_____

ANY PROBLEMS WITH BLOOD PRESSURE? HIGH_____LOW_____

ARE YOU PREGNANT OR NURSING?_____

ARE YOU TAKING ANY MEDICATIONS?____IF SO WHAT?_____

_____

ANY OTHER INFORMATION WE MAY NEED TO KNOW?_____

_____

NAME OF MEDICAL DOCTOR:_____PHONE#_____

PHARMACY:_____PHONE #_____

PATIENT'S SIGNATURE:_____

REVIEWED BY DR:_____DATE:_____

For office use only:

Updated: _____ Patient's Initials_____ Updated: _____ Patient's Initials_____