endodontic associates

patient information (print clearly)

Miss/Ms/Mrs/Mr/Dr_____,_____
last first

Address_____Birthdate_____
street city zipcode

Occupation_____SocSec#_____HomePhone_____

Place of Business_____BusinessPhone_____Cell Phone_____

Parents, Husband's, Wife's 1st Name_____Place of Business_____

Are you covered by Dental Insurance?_____Prim. Ins._____Sec.Ins._____

Referring Dentist_____
name city

medical history (check answers, circle and explain where appropriate)

1. Are you presently under the care of a physician? YES ( ) NO ( )
   if so, for what?_____
2. Are you currently taking any medications? YES ( ) NO ( )
   names _____
3. Do you have any allergies to any medication like penicillin, aspirin, codeine, novocaine, sulfa, or latex ?
   if yes, which one ?_____
4. Do any of the following apply to you? (circle YES or NO)

Rheumatic Fever	YES	NO	Diabetes	YES	NO	Bleeding Problems	YES	NO
High Blood Pressure	YES	NO	Cancer	YES	NO	Nervous Disorder	YES	NO
Heart Disease	YES	NO	Asthma	YES	NO	Kidney Disease	YES	NO
Heart Murmur	YES	NO	Epilepsy	YES	NO	Liver Disease/Hepatitis	YES	NO
Mitral Valve Prolapse	YES	NO	Ulcers	YES	NO	Tuberculosis	YES	NO

5. Do you have to pre-medicate for medical reasons? YES ( ) NO ( )
6. Have you had any joint replacements, bypass surgery, or prosthetic implants? YES ( ) NO ( )
7. Are you HIV+ or in a high risk group for HIV or have you been exposed to the AIDS virus? YES ( ) NO ( )
8. Do you have a pacemaker? YES ( ) NO ( )
9. If you are a woman, are you pregnant? YES ( ) NO ( )
10. Do you have any medical problems we should be aware of? _____

To the best of my knowledge all of the preceding answers are accurate. Should there be any change in my health history or in my medications, I will inform the doctor or his staff. I also give my permission for the doctor to discuss my treatment with my dentist or physician if necessary.

_X_____
patient signature **date**

If you have been to our office before,

Has there been any change in your health since your last visit?

If so, what ? _____

date_____ patient signature_____

date_____ patient signature_____

date_____ patient signature_____