Advanced Endodontics

PLEASE PRINT

Have you ever been a patient in our practice? If so, when was your most recent visit? _____

PATIENT INFORMATION:

Title_____First Name_____Last Name _____

Street Address:_____

City_____State_____Zip Code: _____

Home Phone:_____-_____-_____ Bus. Phone: _____-_____-_____

Cell Phone: _____-_____-_____ E-mail: _____

Gender_____ Date of Birth_____/_____/_____SS# _____-_____-_____

Occupation:_____

DO YOU HAVE DENTAL BENEFITS? YES_____ NO_____

Primary Subscriber Name _____

Primary Subscriber Date of Birth _____/_____/_____

Relationship to Patient _____

Employer _____ Insurance Company _____

I.D.#_____ Group or Plan #_____

Referred By: _____ General Dentist:_____

Person to contact in case of Emergency_____

Emergency Contact : Home: _____ - _____- _____ Cell : _____-_____-_____

Health History

☐ Yes ☐ No ☐ Unknown 1. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth?
If yes, explain._____

☐ Yes ☐ No ☐ Unknown 2. Has there been any change in your general health within the past year?
If yes explain._____

☐ Yes ☐ No ☐ Unknown 3. Are you under care of a physician for a current problem?
If yes explain._____

☐ Yes ☐ No ☐ Unknown 4. Have you been hospitalized within the past 5 years?
Please specify._____

☐ Yes ☐ No ☐ Unknown 5. Have you received therapy for alcoholism or drug addiction during the past 5 years?

☐ Yes ☐ No ☐ Unknown 6. Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetic/antibiotics/medications?

☐ Yes ☐ No ☐ Unknown 7. Is there any condition concerning your health that the doctor should be told?

☐ Yes ☐ No ☐ Unknown 8. Do you wish to speak to the doctor privately about anything?

☐ Yes ☐ No ☐ Unknown 9. Have you had abnormal bleeding with previous extraction's, surgery, or trauma?

☐ Yes ☐ No ☐ Unknown 10. Have you ever required a blood transfusion?

☐ Yes ☐ No ☐ Unknown 11. Have you ever had radiation for any condition?

☐ Yes ☐ No ☐ Unknown 12. Have you ever tested positively for HIV infection or AIDS? If so state diagnosed and treating Dr.

☐ Yes ☐ No ☐ Unknown 13. Are you required to take antibiotics prior to dental treatment?

14. Do you have, or have had any of the following?

☐ High blood pressure	☐ Sinus trouble	☐ Heart murmur or prolapsed valve	☐ Thyroid problems
☐ Joint prosthesis (hip, knee, etc.)	☐ Diabetes	☐ Hay fever or sinus problems	☐ Gallbladder trouble
☐ Stomach ulcers, colitis	☐ Dialysis	☐ Hepatitis, Jaundice, Liver disease	☐ Congenital heart disease
☐ Kidney problems	☐ Prosthetic heart valve	☐ History of drug abuse	☐ Venereal disease
☐ Psychiatric treatment	☐ Blood disorder	☐ Fainting spells or seizures	☐ Allergy to latex
☐ Epilepsy	☐ Asthma	☐ Cancer	☐ Bruise easily
☐ Low blood pressure	☐ Low blood sugar	☐ Chest pain, angina	☐ Contagious diseases
☐ Swollen ankles, arthritis or joint disease	☐ Irregular heart beat	☐ Cardiac pacemaker	☐ Wear contact lenses
☐ Temporomandibular joint problems (TMJ)	☐ Bronchitis, chronic cough	☐ Delay in healing	☐ History of alcohol abuse
☐ Rheumatic fever or rheumatic heart disease	☐ Problems with immune system	☐ Emphysema	☐ Eye disease or glaucoma
☐ X- Ray treatment or chemotherapy	☐ Chronic fatigue or night sweats	☐ On a diet	☐ Infectious mononucleosis
☐ Difficulty breathing or other lung trouble	☐ Tuberculosis	☐ Heart surgery	
☐ Cardiovascular disease: heart attack, stroke or bypass			

☐ Yes ☐ No ☐ Unknown 15. Do you have any disease, condition or problem not listed? Specify.

☐ Yes ☐ No ☐ Unknown 16. Are you taking Bisphosphonates now or have ever taken them in the past (Fosamax)?

☐ Yes ☐ No ☐ Unknown 17. Are you taking any medications or drugs? If yes, please list below Qty, frequency, name and reason for taking.

_____

_____

Women Only ☐ Possibility of pregnancy ☐ Nursing ☐ Taking birth control pills Estimated delivery date_____