the ENDODONTIC GROUP

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## PATIENT INFORMATION

Date _____

Patient name (first, middle initial, last) _____

What name would you prefer our staff to use? _____

❑ Male ❑ Female Occupation _____

Street address _____ Apt # _____

City _____ State _____ Zip _____ Date of birth _____

Home phone _____ Office phone _____

E-mail address _____ Cell phone _____

What is your general dentist's name? _____

Person to contact in case of emergency _____ Phone _____

## DENTAL INSURANCE INFORMATION

Name of insured _____ Relationship to patient _____

Date of birth _____ Insurance co. phone _____

Employer _____ Work phone _____

Insurance co. name _____

Group # _____ SS#/ID# _____

Insurance co. address _____ City _____ State _____ Zip _____

*Do you have additional dental insurance?* ❑ Yes ❑ No *If yes, please complete the following:*

Name of insured _____ Relationship to patient _____

Date of birth _____ Insurance co. phone _____

Employer _____ Work phone _____

Insurance co. name _____

Group # _____ SS#/ID# _____

Insurance co. address _____ City _____ State _____ Zip _____

## PERSON RESPONSIBLE FOR PAYMENT

Name of person responsible for payment _____ Relationship to patient _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail address _____

Date of birth _____ Driver's license no. _____

Employer _____ Work phone _____

# CONFIDENTIAL DENTAL/MEDICAL HISTORY

*Please print and fill out form completely. Thank you.*

When was the last visit to your general dentist? _____

Chief complaint or reason for your visit today _____

Are you in pain today? ❑ Yes ❑ No Pain to cold? ❑ Yes ❑ No

Pain on biting or pressure? ❑ Yes ❑ No Pain to hot foods/liquids? ❑ Yes ❑ No

Name of physician _____ Office phone _____

Date of last exam _____ Reason for last exam _____

Your current physical health is? ❑ Good ❑ Fair ❑ Poor

Are you taking any medications? ❑ Yes ❑ No If yes, please list _____

_____

_____

*Are you allergic to any of the following?*

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Aspirin | ❑ Yes | ❑ No | Local anesthesia | ❑ Yes | ❑ No | Penicillin / Amoxicillin | ❑ Yes | ❑ No |
| Codeine | ❑ Yes | ❑ No | Latex allergy | ❑ Yes | ❑ No | Other antibiotics | ❑ Yes | ❑ No |
| Clindamycin | ❑ Yes | ❑ No | Tetracycline | ❑ Yes | ❑ No | Other meds (list below) | ❑ Yes | ❑ No |

Please list any other drugs or materials that you are allergic to _____

Do you take aspirin daily? ❑ Yes ❑ No Have you ever been treated with Bisphosphonate drugs? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week #_____ If yes, list: _____

Are you taking birth control pills? ❑ Yes ❑ No Are you a nursing mother? ❑ Yes ❑ No

*Have you ever had any of the following diseases or medical problems?*

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Abnormal heart condition | ❑ Yes | ❑ No | Diabetes | ❑ Yes | ❑ No | Liver disease | ❑ Yes | ❑ No |
| AIDS/HIV | ❑ Yes | ❑ No | Emphysema | ❑ Yes | ❑ No | Mitral valve prolapse | ❑ Yes | ❑ No |
| Alcohol/drug abuse | ❑ Yes | ❑ No | Epilepsy/Seizures | ❑ Yes | ❑ No | Nervous disorder | ❑ Yes | ❑ No |
| Anemia | ❑ Yes | ❑ No | Fainting | ❑ Yes | ❑ No | Pacemaker | ❑ Yes | ❑ No |
| Arthritis | ❑ Yes | ❑ No | Heart attack/surgery | ❑ Yes | ❑ No | Mental Illness | ❑ Yes | ❑ No |
| Asthma | ❑ Yes | ❑ No | Heart murmur | ❑ Yes | ❑ No | Radiation treatment | ❑ Yes | ❑ No |
| Bleeding problems | ❑ Yes | ❑ No | Heart valve replacement | ❑ Yes | ❑ No | Rheumatic fever | ❑ Yes | ❑ No |
| Blood transfusion | ❑ Yes | ❑ No | Multiple Sclerosis | ❑ Yes | ❑ No | Sinus problems | ❑ Yes | ❑ No |
| Breathing problems | ❑ Yes | ❑ No | Hemophilia | ❑ Yes | ❑ No | Steroid therapy | ❑ Yes | ❑ No |
| Cancer/Chemotherapy | ❑ Yes | ❑ No | Hepatitis | ❑ Yes | ❑ No | Stroke | ❑ Yes | ❑ No |
| Colitis | ❑ Yes | ❑ No | Herpes | ❑ Yes | ❑ No | Bacterial Endocarditis | ❑ Yes | ❑ No |
| Congenital heart defect | ❑ Yes | ❑ No | High blood pressure | ❑ Yes | ❑ No | Thyroid treatment | ❑ Yes | ❑ No |
| Defibrillator | ❑ Yes | ❑ No | Kidney disease | ❑ Yes | ❑ No | Ulcers | ❑ Yes | ❑ No |
| Depression | ❑ Yes | ❑ No | Joint replacement | ❑ Yes | ❑ No | Other (please list below) | ❑ Yes | ❑ No |

Is there any other medical condition you have that is not listed above? _____

Have you been hospitalized in the past five years? ❑ Yes ❑ No Reason: _____

I, the undersigned (patient or legally responsible party), authorize the taking of radiographs and/or other diagnostic measures required for a thorough and complete evaluation. I certify that I have read and understand the above and that the information submitted on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian _____ Date _____

First medical update Date: _____ Any changes? ❑ Yes ❑ No

Signature _____ Date _____