• WELCOME TO ENDODONTIC ASSOCIATES, P.C. •

PATIENT INFORMATION:

Date

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name M.I. Last Name Nickname

Sex: ❑ Male ❑ Female Birth Date Age Social Security # E-Mail

Street City State Zip

Home Tel ( ) Cell ( ) Have you ever been a patient of our practice? ❑ Y ❑ N

Employer Business Tel ( )

In case of emergency, please contact Tel ( ) Relation

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

❑ Self (if self, skip to next section) ❑ Spouse ❑ Father ❑ Mother ❑ Other

Name Social Security # Birthdate Age Tel ( )

Street City State Zip

Employer Business Tel ( )

INSURANCE INFORMATION:

Student .....❑ Full Time ❑ Part Time ❑ Not School Name / Address

Martial Status ....❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated

Employed.....❑ Full Time ❑ Part Time ❑ Retired ❑ Not

PRIMARY INSURANCE COMPANY:

Insurance Type: ❑ Dental ❑ Medical (for accidents only)

Employer

Insurance Company Name

Address

Tel ( )

Group # Group Name

Insured Name Relation

Sex: ❑ Male ❑ Female Birth Date

Street

City State Zip

Tel ( ) Social Security #

ID #

SECONDARY INSURANCE COMPANY:

Insurance Type: ❑ Dental ❑ Medical (for accidents only)

Employer

Insurance Company Name

Address

Tel ( )

Group # Group Name

Insured Name Relation

Sex: ❑ Male ❑ Female Birth Date

Street

City State Zip

Tel ( ) Social Security #

ID #

DENTAL INFORMATION:

What is the reason for your dental visit today?

Date of your last dental exam Name of your dentist How long have you been their patient?

MEDICAL INFORMATION:

	Yes	No	DK
Are you under the care of a physician?	❑	❑	❑
Physician name Phone ( )			
Are you in good health?	❑	❑	❑
Has there been any change in your general health within the past year?	❑	❑	❑
• If yes, what condition is being treated?			
Date of last physical exam			
Have you had a serious illness, operation or been hospitalized in the past 5 years?	❑	❑	❑
• If yes, what was the illness or problem?			
Are you taking or have you recently taken any prescription or over-the-counter medication(s)?	❑	❑	❑
• If so, please list all, including vitamins, natural or herbal preparations and / or diet supplements:			
Are you taking, or have you taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	❑	❑	❑
Are you taking, or scheduled to begin taking, either of the medication, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	❑	❑	❑
Since 2001, were you treated, or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, nypercalcernia or skeletal complications resulting from Paget's disease, multiple myeloma or metastiaic cancer?	❑	❑	❑
• If so, date treatment began:			
Have you been treated for a drug or alcohol dependency?	❑	❑	❑
• If yes, when:			

Women Only:

	Yes	No	DK
Are your pregnant?	❑	❑	❑
• If yes, number of weeks: _____			
Are you taking birth control pills or hormonal replacement?	❑	❑	❑
Are you nursing	❑	❑	❑

Joint Replacement:

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	❑	❑	❑

Allergies: Are you allergic to, or have you had a reaction to: (to all **YES** responses, specify the type of reaction)

Local anesthetics _____	❑	❑	❑
Aspirin _____	❑	❑	❑
Penicillin, or other antibiotics _____	❑	❑	❑
Barbiturates, sedatives, or sleeping pills _____	❑	❑	❑
Codeine or other narcotics _____	❑	❑	❑
Latex (rubber) _____	❑	❑	❑
Other (please list): _____			
_____			

Please check your response (Y=Yes, N=No, DK=Don't Know) to indicate if you have, or have not, had any of the following diseases or problems:

	Y	N	DK
Heart murmur	❑	❑	❑
Mitral valve prolapse	❑	❑	❑
Artificial heart	❑	❑	❑
Rheumatic fever	❑	❑	❑
Cardiovascular disease	❑	❑	❑
Angina	❑	❑	❑
Arteriosclerosis	❑	❑	❑
Congestive heart failure	❑	❑	❑
Coronary artery disease	❑	❑	❑
Damaged heart valve	❑	❑	❑
Heart attack	❑	❑	❑
Low blood pressure	❑	❑	❑
High blood pressure	❑	❑	❑
Congenital heart disease	❑	❑	❑
Pacemaker	❑	❑	❑
Rheumatic heart disease	❑	❑	❑
Abnormal bleeding	❑	❑	❑

	Y	N	DK
Anemia	❑	❑	❑
Blood transfusion	❑	❑	❑
• If yes, date _____			
Hemophilia	❑	❑	❑
AIDS or HIV disease	❑	❑	❑
Arthritis	❑	❑	❑
Autoimmune disease	❑	❑	❑
Rheumatoid arthritis	❑	❑	❑
Systemic lupus erythematosus	❑	❑	❑
Asthma	❑	❑	❑
Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
Sinus trouble	❑	❑	❑
Tuberculosis	❑	❑	❑
Cancer / Chemotherapy /			
Radiation treatment	❑	❑	❑
Chest pain upon exertion	❑	❑	❑

	Y	N	DK
Chronic pain	❑	❑	❑
Diabetes: Type I or II	❑	❑	❑
Eating disorder	❑	❑	❑
Malnutrition	❑	❑	❑
Gastrointestinal disease	❑	❑	❑
G.E. Reflux / Persistent			
Heartburn	❑	❑	❑
Ulcers	❑	❑	❑
Thyroid problems	❑	❑	❑
Stroke	❑	❑	❑
Glaucoma	❑	❑	❑
Hepatitis / Jaundice /			
Liver disease	❑	❑	❑
Epilepsy	❑	❑	❑
Fainting spells or seizures	❑	❑	❑
Neurologic disorders	❑	❑	❑
• If yes, specify _____			

	Y	N	DK
Sleep disorder	❑	❑	❑
Mental health disorders	❑	❑	❑
• Specify _____			
Recurrent infections	❑	❑	❑
• Type of infection _____			
Kidney problems	❑	❑	❑
Night sweats	❑	❑	❑
Osteoporosis	❑	❑	❑
Persistent swollen glands			
in neck	❑	❑	❑
Severe headaches /			
Migraines	❑	❑	❑
Server or rapid weight loss	❑	❑	❑
Sexually transmitted disease	❑	❑	❑
Excessive urination	❑	❑	❑

Has your physician, or previous dentist, recommended that you take antibiotics prior to your dental treatment? ❑ ❑ ❑

Name of physician or dentist making recommendation _____ Phone (____) _____

I certify that I have read and I understand the Questions above. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of the form.

_____ Date _____

(Signature of Patient or Guardian)

FEES, PAYMENTS, and PRIVACY: We make every effort to keep down the cost of your care. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental/medical insurance we will be glad to fill out the proper forms, but please make sure that you provide our office with the correct information in order for us to submit the claims. I authorize this office to provide any information that is requested by the insurance company and or my general dentist. I hereby authorize payment to this doctor named of the benefits otherwise payable to me. I understand that any amount not paid by the insurance company (if applicable) and/or any amount not paid after 60 days become my responsibility regardless of any third party involvement. After 60 days I understand that I will be charged a monthly finance charge for any unpaid amount. I understand that this office does not share any of my personal information with anyone except my general dentist office or insurance company without my permission.

_____ Date _____

(Signature of Patient or Guardian)