ENDODONTIC SOLUTIONS

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GENERAL INFORAMTION

Patient's Name // ______________________ Date of Birth // __________ Sex // ____F _____M

Home Address // ______________________ City // __________ Zip // __________ SSN // __________

Home Phone // __________ Cell Phone // __________ Emergency Contact Name & No. // ______________

OCCUPATIONAL INFORMATION

Occupation // ______________________ Employed by // __________ Business Phone // __________

Name of Spouse // ______________ Spouse Employed by // __________ Spouse's Business Phone // __________

Referring Dentist // ______________ Family Physicians // ______________ Physician Number // ______________

DENTAL INSURANCE INFORMATION

Subscriber's Name // ______________________ Date of Birth // __________ SSN // __________

Insurance Co. // ______________________ I.D. No. // __________ Group No. // __________

MEDICAL HISTORY

Yes	No		Yes	No	
☐	☐	High blood pressure	☐	☐	Arthritis
☐	☐	Low blood pressure	☐	☐	Stomach ulcers, colitis
☐	☐	Heart murmur or mitral valve prolapse	☐	☐	Hepatitis, jaundice, liver disease
☐	☐	Joint prosthesis (hip, knee, etc.)	☐	☐	Psychiatric treatment
☐	☐	Heart disease, surgery	☐	☐	Fainting spells or seizures
☐	☐	Prosthetic heart valve	☐	☐	Epilepsy
☐	☐	Blood disorder	☐	☐	Cancer, Type // ______________
☐	☐	Sexually Transmitted disease	☐	☐	Temporomandibulor joint problems (TMJ)
☐	☐	Asthma, Lung disease	☐	☐	Low blood sugar
☐	☐	Cardiac pacemaker	☐	☐	Dialysis
☐	☐	Tuberculosis	☐	☐	Irregular heart beat
☐	☐	X-ray treatment or chemotherapy	☐	☐	Contagious diseases
☐	☐	Sinus trouble	☐	☐	History of drug abuse
☐	☐	Diabetes	☐	☐	None of the above

Yes	No	
☐	☐	Are you in good health? Date of last physical exam ______/______/__________
☐	☐	Are you being treated by a physician now? List any drugs, medications, vitamins or food supplements now being taken // ______________________
☐	☐	Have you had excessive bleeding requiring special treatment?
☐	☐	Have you ever tested positive for HIV?
☐	☐	Have you had surgery within the last five years? If yes, for what? ______________
☐	☐	Are you allergic to any drugs or latex? If yes, which drugs? ______________
☐	☐	Does you physician require you to take antibiotics for you dental visits?
☐	☐	Do you take any blood thinning agents? If yes, please list // ______________
☐	☐	Women only: Are you pregnant (or possibly pregnant)?
☐	☐	Women only: Are you currently taking birth control pills?
☐	☐	Women only: Are you currently nursing?

Patient Signature // ______________________________ Date // ______________