Name_____ Birthdate_____

Address_____

Primary Phone_____ Secondary Phone _____

Email Address_____

Age_____ Sex_____ Height_____ Weight_____ Marital status_____

Physician_____ Physician Phone:_____

Referring Dentist _____

Emergency Contact_____ Phone_____

PLEASE ANSWER EACH QUESTION **YES NO**

1. Have you been a patient in the hospital in the past two years? ..... ☐ ☐
   Reason _____
2. Have you been under the care of a physician during the past year? ..... ☐ ☐
   Reason _____
3. Do you currently pre-medicate for dental procedures? ..... ☐ ☐
4. Are you taking any kind of medication or drugs at this time? ..... ☐ ☐
   Please list _____
   _____
   _____
5. Have you ever had an unusual reaction to:
   a. any drugs or medicine (penicillin, etc.)_____ ☐ ☐
   b. local anesthetic..... ☐ ☐
6. Are you subject to prolonged bleeding? ..... ☐ ☐

Circle any of the following which you have had:

Heart Trouble	Diabetes	Epilepsy
Heart Murmur	Tuberculosis	Glaucoma
Rheumatic Fever	Hepatitis	Radiation Therapy
High Blood Pressure	Jaundice	Allergies
Anemia	Arthritis	Kidney Trouble
Asthma	Stroke	Psychiatric Treatment
Fainting Spells	Blood Disorders	Joint Replacement
Other		

YES NO

7. Are you pregnant? ..... ☐ ☐
8. Is there any other information we should know about your health or previous dental visits? _____ ☐ ☐
9. Have you ever tested positive for HIV? ..... ☐ ☐
10. Have you ever taken bisphosphonates?..... ☐ ☐

Account Information over→

Responsible Party's Name _____

Birthdate_____Social Security No._____Sex:___F___M

Street Address_____Phone_____

Responsible Party's Employer_____No. of Years Employed

Driver's License #_____Expiration Date _____

Email address_____

FOR PATIENTS COVERED BY DENTAL INSURANCE

Insurance Company _____

Subscriber's Name _____

Subscriber ID/ Soc #_____Birthdate_____

Subscriber's Employer_____Group No. _____

Patient's Relationship to Subscriber: Self Spouse Dependent

Fill Out Next Section **if** you have a secondary insurance.

SECONDARY DENTAL INSURANCE

Insurance Company _____

Subscriber's Name _____

Subscriber ID/ Soc #_____Birthdate_____

Subscriber's Employer_____Group No. _____

For the endodontic services rendered, I hereby authorize payment of group insurance benefits, otherwise payable to me, to be made directly to this dental office.I hereby give permission to release the records of my treatment to the Group Benefits Insurance office of interest and to my referring dentist.

I understand that I am responsible for all costs of dental treatment. I hereby authorize this dental office to administer such medication and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge.

Signed by Patient/Guardian:_____Date _____