PATIENT'S NAME _______________ Today's Date__________
Home Address_______________ Apt# __________
City_______________State_______________Zip __________
SSN _______________ Date of Birth __________
Home Phone __________Work Phone __________ Mobile Phone__________
Patient's Employer _______________
Driver's License# _______________
General Dentist _______________

INSURANCE COMPANY: _______________ Ins. Phone# __________
Subscriber Name _______________ Date of Birth __________
Subscriber Employer _______________ Work Phone __________
Subscriber SSN or ID# _______________ Group# __________

IF PATIENT IS A MINOR:
Parent/Guardian Name _______________ Home Phone__________
Parent SSN _______________ Date of Birth__________

Primary Care Physician _______________**Phone**__________
Notify in case of emergency_______________
Relationship _______________**Phone**__________

Preferred Pharmacy _______________**Phone** __________
Address _______________

ACCOUNT # __________

OFFICE USE ONLY

Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Tooth:	Tooth:	Tooth:	Tooth:	Tooth:	Tooth:	Tooth:	Tooth:
Eval Chck SR	Eval Chck SR	Eval Chck SR	Eval Chck SR	Eval Chck SR	Eval Chck SR	Eval Chck SR	Eval Chck SR
Rct Retx PR	Rct Retx PR	Rct Retx PR	Rct Retx PR	Rct Retx PR	Rct Retx PR	Rct Retx PR	Rct Retx PR
Apico Bone	Apico Bone	Apico Bone	Apico Bone	Apico Bone	Apico Bone	Apico Bone	Apico Bone
PS CBU PCBU	PS CBU PCBU	PS CBU PCBU	PS CBU PCBU	PS CBU PCBU	PS CBU PCBU	PS CBU PCBU	PS CBU PCBU
PF CBCT N20	PF CBCT N20	PF CBCT N20	PF CBCT N20	PF CBCT N20	PF CBCT N20	PF CBCT N20	PF CBCT N20
INOP RtAmp	INOP RtAmp	INOP RtAmp	INOP RtAmp	INOP RtAmp	INOP RtAmp	INOP RtAmp	INOP RtAmp
Start/Finish	Start/Finish	Start/Finish	Start/Finish	Start/Finish	Start/Finish	Start/Finish	Start/Finish
Dr: Asst:	Dr: Asst:	Dr: Asst:	Dr: Asst:	Dr: Asst:	Dr: Asst:	Dr: Asst:	Dr: Asst:
NV:	NV:	NV:	NV:	NV:	NV:	NV:	NV:

OFFICE USE ONLY

MEDICAL HISTORY

Have you ever had? (Check Appropriate Box)

Yes	No		Yes	No	
☐	☐	Heart Murmur/MVP	☐	☐	Migraine/Headaches
☐	☐	Heart Disease	☐	☐	Currently Pregnant/Breast Feeding
☐	☐	Rheumatic Fever	☐	☐	Herpes
☐	☐	High Blood Pressure	☐	☐	Immunocompromised
☐	☐	Liver Disease	☐	☐	Chest Pain
☐	☐	HIV Positive	☐	☐	Radiation/Chemotherapy
☐	☐	Diabetes	☐	☐	TMJ Problems (Jaw)
☐	☐	Lung Disease/Asthmas	☐	☐	Pacemaker
☐	☐	Excessive Bleeding	☐	☐	Prosthetic Implant
☐	☐	Thyroid Problems	☐	☐	Joint Replacement
☐	☐	Hepatitis	☐	☐	Arthritis
☐	☐	Tuberculosis	☐	☐	Heart Attack
☐	☐	Epilepsy	☐	☐	Stroke

Are you taking any medications? ☐ **Yes** ☐ **No**

Please List: ____________________________

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Do you have any allergies? ☐ **Yes** ☐ **No**

Aspirin	☐ **Yes**	☐ **No**
Penicillin	☐ **Yes**	☐ **No**
Local Anesthetic	☐ **Yes**	☐ **No**
Codeine	☐ **Yes**	☐ **No**
Latex	☐ **Yes**	☐ **No**

Please List: ____________________________

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Do you have any other medical conditions? ☐ **Yes** ☐ **No**

If yes, please explain: ____

Are you under medical treatment for any medical conditions? ☐ **Yes** ☐ **No**

If yes, please explain: ____

Have you had surgery in the past five years? ☐ **Yes** ☐ **No**

If yes, please explain: ____

Do you premedicate or routinely take antibiotics before dental treatment? ☐ **Yes** ☐ **No**

If yes, which antibiotic? ____

Is there additional health information you feel we should know? ____________________

____

I understand the importance of a truthful health history to assist the doctor in providing the best care possible. I understand that I have the opportunity to discuss my health history with the doctors and assistants at Endodontic Specialists.

X Signature of responsible party ______________________ Date__________