



MEDICAL HISTORY

Have you ever taken: Bisphosphonates (ex. Actonel/Fosamax) Yes NO or Phen-fen/Redux YES NO

Are you allergic to any of the following? Latex Penicillin/Amoxicillin Sulfa Aspirin Dental Anesthetics

Others (please list) _____

Do you have or have you had any of the following diseases, medical conditions or procedures? (Please check if yes)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Heart Surgery/Pacemaker | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diabetes/Hypoglycemia |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> HIV+/AIDS/ARC | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Artificial Valves | <input type="checkbox"/> Stomach Problems/Ulcers | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Fainting/Seizures/Epilepsy | <input type="checkbox"/> Anticoagulants |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Severe/Frequent Headaches | <input type="checkbox"/> Steroid |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Frequent Neck Pain | |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Back Problems | |
| <input type="checkbox"/> Tuberculosis TB | <input type="checkbox"/> Jaw Problems TMJ/TMD | <input type="checkbox"/> Asthma | |

Please list any other surgeries or medical conditions you have ever had: _____

Are you taking any medications? If yes, please list: _____

Women: Are you pregnant? N Y/How long? _____ Are you nursing? No Yes Birth control pills? No Yes

Do you use tobacco? No Yes/How used? _____ How much? _____ How Long? _____

Are you under the care of a physician? N Y If so, Physician's name and why _____

We invite you to discuss with us any questions regarding our services.

➤ *I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.*

Signature _____ **Date** ____/____/____

Adult patient Parent or Guardian Spouse

Patient's Name: _____ Date of Birth: ____/____/____
LAST FIRST MI

What do you prefer to be called: _____ MALE FEMALE SS #: _____ - _____ - _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) _____ Home Phone: (____) _____

Emergency Contact: (____) _____ Relationship: _____ Phone: (____) _____

Employer: _____ Occupation: _____ Business Phone: (____) _____

Referred By: _____ General Dentist: _____

Primary Dental Insurance: _____ Member ID# _____ Group # _____

Policy Holders Name: _____ Relation to Patient _____

Policy Holders Address (if not same as patient) _____ Date of Birth: ____/____/____

____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

Initials I fully understand I am solely responsible for any balance not paid by my insurance company (if offered in this office).

Consent for Treatment

I, the undersigned, being the patient, parent or guardian consent to the performing of procedures decided upon to be necessary or advisable in this office, I shall return to my general family dentist for a permanent restoration of the tooth involved, such as a crown or permanent filling within **no more than four weeks** of endodontic treatment.

I understand that root canal treatment is an attempt to save a tooth which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure and cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery or even extraction.

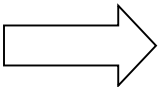


Signature

Date

(See laminated sheets, copy provided upon request)

I am confirming that I have read and understand the financial policy of this office and that I am agreeing to fulfill my financial obligation today to this office.



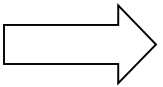
Signature

Date

____Adult patient ____Parent or Guardian ____Spouse

I have read a copy of the Notice of Privacy Practices for the above named practice.

(See laminated sheets, copy provided upon request)



Signature

Date

Name of any person you give consent for us to release information to:

_____, _____, _____



Please complete Medical History on back side

