Patient Information Form

Certified Specialists in Endodontics
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PLEASE PRINT

Name ______________________________ Cellular # ____________
last first initial

Address ______________________________ Other Tel # ____________
house # street city postal code

Email Address ______________________________ Occupation ____________

Birthdate ______________ Circle: Male / Female Health Card # ____________
day month year

Family Dentist ______________________________ City ____________

Family Physician ______________________________ City ____________

Parent/Guardian Name (if under 18 years): ______________________________

Relative or Friend's Name & Telephone (emergency) ______________________________

In compliance with anti-spam laws, by giving us your cellular and email, you are consenting to us communicating with you via email or text

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Dental Insurance

Name of Policy Holder ______________________________ Birthdate ____________
Day Month Year

Employer ______________________________

Insurance Co. ______________________________

Group Policy/Plan # ____________ Cert # ______________ Dep# ____________

Relationship to Policy Holder ______________________________

Second Insurance Plan (if applicable)

Name of Policy Holder ______________________________ Birthdate ____________
Day Month Year

Employer ______________________________

Insurance Co. ______________________________

Group Policy/Plan # ____________ Cert # ______________ Dep # ____________

Relationship to Policy Holder ______________________________

If the policy holder of your primary and/or secondary coverage is someone other than yourself, we may be required to communicate with policy holder(s) of the plan regarding your account.

OVER

Confidential Medical History

Date of your last physical exam ______________________

Do you have a major medical problem? ☐ YES ☐ NO

If yes, please describe: ______________________

Have you been hospitalized in the past 5 years? ☐ YES ☐ NO

If yes, please describe: ______________________

Have you been in the care of a medical doctor during the past two years? ☐ YES ☐ NO

If yes, for what reason? ______________________

Have you ever had excessive bleeding following medical/dental surgery? ☐ YES ☐ NO

Do you regularly take medication or drugs of any kind? ☐ YES ☐ NO

If yes, please identify: ______________________

Its purpose: ______________________

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath or because you are very tired? ☐ YES ☐ NO

Has your medical doctor ever said you have a cancer or tumor? ☐ YES ☐ NO

Do you have heart trouble? ☐ YES ☐ NO

WOMEN: Are you pregnant now? ☐ YES ☐ NO

Only Check Boxes that apply.

- ☐ Heart Failure
- ☐ Heart Disease
- ☐ Angina Pectoris
- ☐ Heart Attack
- ☐ Heart Valve Problems
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Congenital Heart Lesions
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse - Regurgitation

Check any of the following which you have had or have at present:

- ☐ Anemia
- ☐ Stroke
- ☐ Diabetes Type 1 / Type 2
- ☐ Epilepsy or Seizures
- ☐ Hemophilia
- ☐ Artificial Joint
- ☐ Ulcer
- ☐ Glaucoma
- ☐ Allergies or Hives
- ☐ Sinusitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Radiation Treatment
- ☐ Chemotherapy (Cancer/Leukemia)
- ☐ Colitis
- ☐ Fainting or Dizzy Spells
- ☐ Psychiatric Treatment

Diseases

- ☐ Kidney
- ☐ Liver

Allergies (Drugs):

- ☐ Penicillin
- ☐ Local Anesthetic
- ☐ Codeine
- ☐ Aspirin
- ☐ Other ______________

Infectious Disease:

- ☐ HIV/Exposure to Aids
- ☐ Hepatitis B
- ☐ Hepatitis C

Any serious illness not listed? ______________________

To the best of my knowledge, all of the preceding answers are true and correct. IF I EVER HAVE ANY CHANGE IN MY HEALTH, OR IF MY MEDICINES CHANGE, I WILL INFORM THE DOCTOR AT THE NEXT APPOINTMENT WITHOUT FAIL.

____
Signature of Patient, Parent or Guardian

Date ______________

____
Doctor's/Staff signature

Date ______________