ENDODONTIC SPECIALISTS. LTD. / PATIENT INFORMATION FORM

Full Legal Name_______________________________________ I prefer to be called__________________________________

Address ____ City ___________________ State _____ Zip___________

Sex ______ Height _______ Weight _______ Age ______ Date of Birth ________________ SS# _____________________

Home Phone # ______________________________________ Cell Phone # ____

Employer _______________________________________ Business Phone # ____________________________ Ext. ______

Name of Group Dental Plan ______________________________ Group # ____

Insured's SS # or ID # ___________________________________ Referred by _______________________________________

Marital Status ________________________ Name of Spouse ____

Spouse's Employer ___________________________________ Business Phone #________________________ Ext. _______

Parent's Names (if patient is under 18 yrs. or a full-time student) ____

Father's Employer ___________________________________ Business Phone # ________________________ Ext. _______

Mother's Employer ___________________________________ Business Phone # ________________________ Ext. _______

Father's SS # ____ Mother's SS # _______________________________________

In the following questions, circle yes or no, whichever applies. Your answers are for our records only will be considered confidential

Yes No 1. Are you in good health? ____

Yes No 2. Has there been any change in your general health within the past year? __________________________________

Yes No 3. My last physical examination was on ____

Yes No 4. Are you now under the care of a physician? ____

Yes No 5. The name and address of my physician is ____

____

Yes No 6. Have you been hospitalized or had a serious illness within the past five (5) years? _________________________

If so, what was the problem? ____

7. Do you have or had any of the following diseases or problems?

Yes No a. Damaged heart valves or artificial heart valves, including heart murmur___________________________________

Yes No b. Congenital heart lesions ____

Yes No c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ____

Yes No 1. Do you have pain in chest upon exertion? ____

Yes No 2. Are you ever short of breath after mild exercise? ____

Yes No 3. Do your ankles swell? ____

Yes No 4. Do you get short of breath when you lie down, or do you require extra pillows when you sleep?________________

Yes No 5. Do you have a cardiac pacemaker? ____

Yes No d. Allergy ____

Yes No e. Sinus trouble ____

Yes No f. Asthma or hay fever ____

Yes No g. Hives or a skin rash ____

Yes No h. Fainting spells or seizures ____

Yes No i. Diabetes ____

Yes No 1. Do you have to urinate (pass water) more than six times a day? ____

Yes No 2. Are you thirsty much of the time? ____

Yes No 3. Does your mouth frequently become dry? ____

Yes No j. Hepatitis, jaundice or liver disease ____

Yes No k. Arthritis ____

Yes No l. Inflammatory rheumatism (painful swollen joints) ____

Yes No m. Artificial joint (joint replacement) ____

Yes No n. Stomach ulcers ____

Yes No o. Kidney trouble ____

Yes No p. Tuberculosis ____

Yes No q. Do you have a persistent cough or cough up blood? ____

Yes No r. Low blood pressure ____

Yes No s. Venereal disease ____

Yes No t. Epilepsy ____

Yes No u. Psychiatric problems ____

Yes No v. Cancer ____

Yes No w. AIDS or other immunosuppressive disorders ____

Yes No x. Other ____

Yes No 8. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? ____________________________

Yes No a. Do you bruise easily? ____

Yes No b. Have you ever required a blood transfusion? ____

Yes No 9. Do you have any blood disorder such as anemia? ______________________________

Yes No 10, Have you had surgery, x-ray or drug treatment for a tumor, growth, or other condition of your head or neck?________________

Yes No 11. Are you taking any of the following:

Yes No a. Antibiotics or sulfa drugs ______________________________

Yes No b. Anticoagulants (blood thinners) ______________________________

Yes No c. Medicine for high blood pressure ______________________________

Yes No d. Cortisone (steroids) ______________________________

Yes No e. Tranquilizers ______________________________

Yes No f. Antihistamines ______________________________

Yes No g. Aspirin ______________________________

Yes No h. Insulin, tolbutamide (Orinase) or similar drug ______________________________

Yes No i. Digitalis or drugs for heart trouble ______________________________

Yes No j. Nitroglycerin ______________________________

Yes No k. Oral contraceptive or other hormonal therapy______________________________

Yes No l. Other ______________________________

12. Are you allergic or have you reacted adversely to:

Yes No a. Local anesthetics ______________________________

Yes No b. Penicillin or other antibiotics ______________________________

Yes No c. Sulfa drugs ______________________________

Yes No d. Barbiturates, sedatives, or sleeping pills ______________________________

Yes No e. Aspirin ______________________________

Yes No f. Iodine ______________________________

Yes No g. Codeine or other narcotics ______________________________

Yes No h. Other ______________________________

Yes No 13. Have you had any serious trouble associated with any previous dental treatment? ______________________________

If so, explain ______________________________

____

Yes No 14. Do you have any disease, condition, or problem not listed above that you think I should know about? ______________________

If so, explain ______________________________

Yes No 15. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? ______________________

Yes No 16. Are you wearing contact lenses? ______________________________

Yes No 17. Have you had anything to eat or drink in the last 4 hours? ____

Yes No 18, Are you wearing removable dental appliances? ____

WOMEN

Yes No 19. Are you pregnant? ____

Yes No 20. Do you have any problems associated with your menstrual period? ____

Yes No 21. Are you nursing? ____

** 22. How will you be paying for your visit today – CASH / CHECK / MC / VISA? (Please circle one) ________________________

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient **Date**

Signature of Dentist **Date**