ENDODONTICS DDS
Practice Limited to Endodontics

Patient Information

Date _____ ID/SSN _____

Patient Name:
_____
Address:
_____
_____
City State ZIP
Date of Birth _____
Gender: □ Male □ Female
□ □ □ □ □

Home (_____) _____
Work (_____) _____
Cell (_____) _____
Occupation: _____
_____
Employer
_____
Employer Address
_____
_____
City State ZIP

Emergency Contact:
Name: _____
Phone: _____
Relationship: _____

Primary Insurance

Subscriber's Name:
_____
DOB _____ SSN _____
Relationship to Patient: _____
Insurance Co. _____
Group #: _____

Secondary Insurance

Subscriber's Name:
_____
DOB _____ SSN _____
Relationship to Patient: _____
Insurance Co. _____
Group #: _____

Assignment and Release Information

I, the undersigned, certify that I (or my dependent) have aforementioned insurance coverage and assign directly to Endodontics DDS all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

_____
Responsible Party's Signature

_____
Relationship Date

(over)

Dental and Medical History

Dental History

Reason For Today's Visit _____

Check [✓] if you have had problems with any of the following:

☐ Grinding Teeth ☐ Sensitivity to Cold/hot ☐ Sensitivity to Sweet
☐ Clicking or popping jaw ☐ Periodontal Treatment ☐ Orthodontic Treatment

Are you a smoker? ☐ Yes ☐ No

Medical History

Physician's Name _____ Date of Last Physical_____
Have you ever had any of the following? Check Yes or No

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Murmur	☐	☐	Epilepsy	☐	☐	Heart Problem
☐	☐	Glaucoma	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	AIDS/HIV	☐	☐	Radiation Treatment	☐	☐	Artificial Heart Valve/Joints
☐	☐	Cancer	☐	☐	Herpes	☐	☐	Anemia
☐	☐	Headaches	☐	☐	Liver Disease	☐	☐	Ulcer
☐	☐	Rheumatic fever	☐	☐	Blood Disease	☐	☐	Bleed Abnormally
☐	☐	Low Blood Pressure	☐	☐	Sinus Problem	☐	☐	Fainting/Dizziness
☐	☐	Hepatitis	☐	☐	Cough, persistent	☐	☐	Stroke
☐	☐	Pacemaker	☐	☐	Asthma	☐	☐	Kidney Disease
☐	☐	Thyroid Problem	☐	☐	Jaundice	☐	☐	Sexually Transmitted Disease
☐	☐	Substance Dependency	☐	☐	Circulatory Problems	☐	☐	Psychiatric Care

Have you had any serious illness or operations? _____ If yes, describe _____
_____
_____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Women – Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No

Medications

List medication you are currently taking:
_____
_____
_____
_____

Allergies

☐ Aspirin ☐ Local Anesthetic
☐ Barbiturates (sleeping pills)
☐ Sulfa ☐ Latex
☐ Penicillin ☐ Codeine
☐ OTHER:_____

Signature

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature Date Reviewed By Doctor