PATIENT INFORMATION

Legal Name			Pref	erred Name			
First	Mid. Initial Last						
Mailing AddressStreet/ P.O. Box		 Unit #	City		State	Zip	
Cell Phone						•	
Social Security #							
Check appropriate space: Single							
Spouse Name							
First	Mid. Initial Li	ast				\Box	
E-mail							
Employer (company name/city)							
Whom may we thank for referring yo	u?						
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	<u>EIPT OF HIPAA NO</u>						
PRINT NAME:	<mark>(</mark>	GIGNATURE:			DATE: _		
l authorize Center for Endodontic Car			_				
<u>Name</u>	Relationship to Patient		Financial/Insurance?				
			Yes / No	Yes			
				Yes			/ No
	<u>DEN</u>	<u>ITAL INSU</u>	RANCE				
Insurance Co				Phone #			
Claims Mailing Address							
Subscriber ID#			Group #				
Group Name (employer's name, "Self	f", etc.)						
Subscriber's Name			Relationsh	nip to Patient			
Subscriber's Mail Address (if differen	t from patient)						
Carial Carrotto Novalan	•	P.O. Box		# City	Sta		•
Social Security Number	Date o	of Birth	Day F	none			
			<u>L INSURANCE</u>				
Is the patient covered by additiona							
Insurance Co				Phone #			
Claims Mailing Address							
Subscriber ID#			Group #				
Group Name (employer's name, "Self	f", etc.)						
Subscriber's Name			Relationsh	nip to Patient			
Subscriber's Mail Address (if differen			,	и С:t-			
Cacial Cacumity Normalian	•	P.O. Box		# City	Sta		ip
Social Security Number	Date o	or Rirth	Day F	none			

IF DENTAL INSURANCE APPLIES: Although this office files insurance claims as a service to our patients, the insurance contract is between the patient & the insurance company. As we have no control over the insurance company's processing policies or amount of payment, any amount not paid by insurance is entirely the responsibility of the patient.

INITIALS: ______

MEDICAL HISTORY

Please complete EVERY question so that we may thoroughly diagnose your condition. The information you provide is for our records and will be considered strictly confidential. In addition, it is your responsibility to update this medical history when any changes occur.

Reason: Have you been hospitalized in the past five years? Have you been hospitalized in the past five years? Have you required to take premeds prior to dental treatment? WHY? Have you received therapy for alcoholism or drug addiction during the past five years? Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetics, antibiotics, or other medications? Please explain and the reaction it causes: Have you ever required a blood transfusion? Please explain: Have you ever had surgery and/or radiation for a tumor, growth, or other condition? Yes No. Are you smoke, snuff, chew, or use canabis? Yes No. O. Are you taking or scheduled to begin taking either of these medications?	1.	Have you ever had an ALLERGIC or ADVERSE REACTION to LATEX? Reaction:				
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Medication:		Medication:Being taken for:				
Being taken for:		Medication:Being taken for:				
Joint replacement Pre-Med? Y / N Angina pectoris Thyroid problems Active tuberculosis Venereal diseases Asthma Controlled? Y / N Last Albuterol Hepatitis Difficult breathing Frequent headaches Emphysema Lung disease Lung disease HIV/AIDS Psychiatric problems Diabetes Last BG Level Controlled? Y / N Blood disorders: Sickle cell disease Heart murmur of prolapsed valve MVP Anemia Abnormal bleeding MOMEN ONLY- Are you: Pregnant? Yes / No Ist No Ist No Ist No Ist No Heart Controlled? Y / N WOMEN ONLY- Are you: Pregnant? Yes / No Ist No						
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Pregnant? Yes / No If yes, number of weeks? Nursing? Yes / No		Congenital heart defects				
Pregnant? Yes / No If yes, number of weeks? Nursing? Yes / No		WOMEN ONLY A				
i aking pirth control pills or normonal replacement? Yes / No						
		raking birth control pills of normonal replacement? Yes / No				

ALL THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE					
Signature of Patient/Legal Guardian:	Date:				