PATIENT INFORMATION

Legal Name _____ Preferred Name _____
First Mid. Initial Last

Mailing Address _____
Street/ P.O. Box Unit # City State Zip

Cell Phone_____Work Phone_____Home Phone_____

Social Security #_____ Date of Birth_____ Male _____ Female _____

Check appropriate space: Single____ Married____ Divorced____ Separated____ Widowed____ Domestic Partner____

Spouse Name _____
First Mid. Initial Last

E-mail

Employer (company name/city) _____

Whom may we thank for referring you? _____

RECEIPT OF HIPAA NOTICE AND AUTHORIZED CONTACTS

PRINT NAME: _____ **SIGNATURE:** _____ **DATE:** _____

I authorize Center for Endodontic Care to discuss these matters with the following:

Name	Relationship to Patient	Treatment?	Financial/Insurance?	Emergency Contact? If Yes, Daytime Phone
_____	_____	Yes / No	Yes / No	Yes-_____ / No
_____	_____	Yes / No	Yes / No	Yes-_____ / No

DENTAL INSURANCE

Insurance Co._____ Phone #_____

Claims Mailing Address_____

Subscriber ID# _____ Group # _____

Group Name (employer's name, "Self", etc.) _____

Subscriber's Name _____ Relationship to Patient _____

Subscriber's Mail Address (if different from patient) _____
Street/ P.O. Box Unit # City State Zip

Social Security Number _____ Date of Birth _____ Day Phone _____

SECONDARY *DENTAL* INSURANCE

Is the patient covered by additional DENTAL insurance YES _____ NO _____ - IF YES, PLEASE COMPLETE THIS SECTION:

Insurance Co._____ Phone #_____

Claims Mailing Address_____

Subscriber ID# _____ Group # _____

Group Name (employer's name, "Self", etc.) _____

Subscriber's Name _____ Relationship to Patient _____

Subscriber's Mail Address (if different from patient) _____
Street/ P.O. Box Unit # City State Zip

Social Security Number _____ Date of Birth _____ Day Phone _____

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.

1. Have you ever had an **ALLERGIC or ADVERSE REACTION to LATEX**? Reaction:_____ **Yes** **No**
2. Are you currently under your medical doctor's care for a current medical problem? ..... **Yes** **No**
   Reason:_____
3. Have you been hospitalized in the past five years? ..... **Yes** **No**
   Reason: _____
4. Are you required to take premeds prior to dental treatment? WHY?_____ **Yes** **No**
5. Have you received therapy for alcoholism or drug addiction during the past five years? ..... **Yes** **No**
6. Have you ever had any **ALLERGIC or ADVERSE REACTIONS to anesthetics**, antibiotics, or other medications? Please explain and the reaction it causes: _____ **Yes** **No**
7. Have you ever required a blood transfusion? Please explain:_____ **Yes** **No**
8. Have you ever had surgery and/or radiation for a tumor, growth, or other condition? ..... **Yes** **No**
9. Do you smoke, snuff, chew, or use canabis?..... **Yes** **No**
10. Are you taking or scheduled to begin taking either of these medications?
    Alendronate (Fosamax®) or Risedronate (Actonel®) for osteoporosis or Paget's disease? ..... **Yes** **No**
11. List any medications you are currently taking:
    Medication:_____Being taken for: _____
    Medication:_____Being taken for: _____
    Medication:_____Being taken for: _____
    Medication:_____Being taken for: _____
    Medication:_____Being taken for: _____
    Medication:_____Being taken for: _____
    Medication:_____Being taken for: _____

12. **Do you or have you ever had any of the following (please check):**

____ Joint replacement Pre-Med? **Y / N**
____ Angina pectoris
____ Thyroid problems
____ Asthma Controlled? **Y / N**
Last Albuterol _____
____ Hepatitis
____ Difficult breathing
____ Frequent headaches
____ Emphysema
____ Lung disease
____ Psychiatric problems
____ Diabetes
Last BG Level _____
Controlled? **Y / N**
____ Blood disorders:
____ Sickle cell disease
____ Anemia
____ Abnormal bleeding

____ High blood pressure- Controlled? **Y / N**
____ Active tuberculosis
____ Venereal diseases
____ Stroke Controlled? **Y / N**
Last episode_____
____ Cancer/chemotherapy
____ Fever blisters
____ Sinus problems
____ Liver disease
____ HIV/AIDS
____ Kidney problems
____ Seizures
Last episode_____
Controlled? **Y / N**
____ Heart Conditions: Pre-Med? **Y / N** Controlled? **Y / N**
____ Heart murmur of prolapsed valve MVP
____ Pacemaker
____ Artificial heart valves
____ Congenital heart defects

WOMEN ONLY- Are you:
Pregnant? **Yes / No** If yes, number of weeks? _____ Nursing? **Yes / No**
Taking birth control pills or hormonal replacement? **Yes / No**

ALL THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE

Signature of Patient/Legal Guardian: _____ Date: _____