Care Endodontics, PC

Please fill out completely, save and email to careendodontics@yahoo.com
Your signature will be collected at our office.

Clear Form | Save Form | Print Form

PATIENT INFORMATION

Date _____
SS or Patient ID # _____
Patient Name _____
If Minor, Parent/Guardian's Name _____
Address _____
City _____
State _____ Zip _____
Driver's Lic. # & State _____
Sex: ◯M ◯F Age _____ Birthdate _____

◯ Married ◯ Widowed ◯ Single ◯ Minor
◯ Separated ◯ Divorced ◯ Partnered for _____ years

Occupation _____
Patient Employer/School _____
Employer/School Address _____
_____
Employer/School Phone# (_____) _____
Spouse's Name _____
Birthdate _____SS# _____
Occupation _____
Spouse's Employer _____
Who is your general dentist? _____

DENTAL INSURANCE

Subscriber's Name _____
Relationship to Patient _____
Birthdate _____SS# _____
Insurance Co. _____
Group# _____ Insurance Ph.# (_____) _____

Is patient covered by secondary insurance? ◯Yes ◯No
Subscriber's Name _____
Relationship to Patient _____
Birthdate _____SS# _____
Insurance Co. _____
Group# _____ Insurance Ph.# (_____) _____

PHONE NUMBERS

Home (_____) _____Work(_____) _____ Ext_____ Cell(_____) _____
Spouse's Work# (_____) _____ Best Place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____
Home Phone (_____) _____Work Phone(_____) _____ Ext_____ Cell Phone(_____) _____

DENTAL HISTORY

Please check ☑ "yes" or "no" to indicate if you have had any of the following:

Mouth breathing	◯Yes	◯No
Mouth pain	◯Yes	◯No
Pain around ear	◯Yes	◯No
Periodontal treatment	◯Yes	◯No
Sensitivity to cold	◯Yes	◯No
Sensitivity to heat	◯Yes	◯No
Sensitivity to sweets	◯Yes	◯No
Sensitivity when biting	◯Yes	◯No
Sores or growths in mouth	◯Yes	◯No
Have you ever had a root canal before?	◯Yes	◯No

If yes, when? _____

Have you ever had any complications following dental treatment? ◯Yes ◯No

If yes, please describe _____
_____
_____

Do you premedicate with an antibiotic prior to Dental treatment? ◯Yes ◯No

MEDICAL HISTORY

Physician's Name _____Date of last visit _____

Phone# (_____) _____ Pharmacy _____Phone# (_____) _____

Please check ☑ "yes" or "no" to indicate if you have had any of the following:

AIDS	○Yes	○No	High Blood Pressure	○Yes	○No	Tuberculosis	○Yes	○No
Anemia	○Yes	○No	HIV Positive	○Yes	○No	Tumors or Growths	○Yes	○No
Arthritis, Rheumatism	○Yes	○No	Jaundice	○Yes	○No	Ulcer	○Yes	○No
Asthma	○Yes	○No	Jaw Pain	○Yes	○No	Venereal Disease	○Yes	○No
Back Problems	○Yes	○No	Kidney Disease	○Yes	○No			
Cancer	○Yes	○No	Liver Disease	○Yes	○No	**Have you ever had or**		
Chemical Dependency	○Yes	○No	Low Blood Pressure	○Yes	○No	**been diagnosed with:**		
Chemotherapy	○Yes	○No	Nervous Problems	○Yes	○No	Artificial Heart Valves	○Yes	○No
Circulatory Problems	○Yes	○No	Psychiatric Care	○Yes	○No	Artificial Joints, Screws,		
Cortisone Treatments	○Yes	○No	Radiation Treatment	○Yes	○No	Pins, etc.	○Yes	○No
Cough, persistent or			Respiratory Disease	○Yes	○No			
bloody	○Yes	○No	Scarlet Fever	○Yes	○No	Bleeding abnormally, with		
Diabetes	○Yes	○No	Shortness of Breath	○Yes	○No	extractions or surgery	○Yes	○No
Emphysema	○Yes	○No	Sinus Trouble	○Yes	○No			
Epilepsy	○Yes	○No	Skin Rash	○Yes	○No	Blood Disease	○Yes	○No
Fainting or dizziness	○Yes	○No	Special Diet/Weight Loss	○Yes	○No	Congenital Heart Lesions	○Yes	○No
Glaucoma	○Yes	○No	Stroke	○Yes	○No	Heart Murmur	○Yes	○No
Headaches	○Yes	○No	Swollen Feet or Ankles	○Yes	○No	Hernia Repair	○Yes	○No
Heart Problems	○Yes	○No	Swollen Neck Glands	○Yes	○No	Mitral Valve Prolapse	○Yes	○No
Hepatitis Type _____	○Yes	○No	Thyroid Problems	○Yes	○No	Pacemaker	○Yes	○No
Herpes	○Yes	○No	Tonsillitis	○Yes	○No	Rheumatic Fever	○Yes	○No

Have you ever been hospitalized or do you have any other health concerns?

○ Yes ○ No

If yes, please describe _____

_____

_____

Women: Are you pregnant?

○ Yes ○ No

Due date _____

Are you nursing? ○ Yes ○ No

Taking birth control pills?

○ Yes ○ No

Have you ever taken any of these medications?

Blood Thinners	○Yes	○No
Coumadin	○Yes	○No
Warfarin	○Yes	○No
Diet Medications	○Yes	○No
Dexfenfluramine	○Yes	○No
Fen-phen	○Yes	○No
Pondimin	○Yes	○No
Redux	○Yes	○No
Levoxyl	○Yes	○No
Synthroid	○Yes	○No

Are you allergic to:

Aspirin	○Yes	○No
Barbiturates	○Yes	○No
Codeine	○Yes	○No
Ibuprofen	○Yes	○No
Latex	○Yes	○No
Local Anesthesia	○Yes	○No
Metals (i.e. gold)	○Yes	○No
Penicillin	○Yes	○No

Other _____

_____

Signatures

Insurance assignment: I certify that I, and/or my dependent(s), have insurance coverage with _____and assign directly to
Name of Insurance Campany(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services required. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent or Guardian Date