

PLEASE PRINT _____ DATE _____

MR. MRS.
MS. DR. _____

Street _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Cell Phone _____ E-mail _____

SS# _____ BIRTH DATE _____

Occupation _____ Referred by Dr. _____

How long have you been his/her patient? _____

Are you a former patient of ours? _____

HEALTH INFORMATION

1. Have you ever had: CIRCLE
- | | | |
|---|-----|----|
| Heart Condition | YES | NO |
| High Blood Pressure | YES | NO |
| Thyroid Condition | YES | NO |
| Hepatitis | YES | NO |
| Gastro Intestinal Problems | YES | NO |
| Kidney Disease | YES | NO |
| Allergies | YES | NO |
| Asthma | YES | NO |
| Sinus Pain | YES | NO |
| Diabetes | YES | NO |
| Abnormal Bleeding | YES | NO |
| Epilepsy | YES | NO |
| Prosthetic Joint Replacement | YES | NO |
| HIV/AIDS | YES | NO |
| Have you ever taken medications for osteoporosis? | YES | NO |
2. (Women) Are you pregnant?YES NO
3. Are you taking any medication or supplements?YES NO

Please list _____

4. Have you ever had an unusual reaction to: CIRCLE
- | | | |
|------------------------|-----|----|
| Latex products | YES | NO |
| Local anesthetic | YES | NO |
| Penicillin | YES | NO |
| Any other drug | YES | NO |

5. Are you being treated by a physician?YES NO
- For what condition(s) _____
- Physician's name: _____

6. Is there any other information about your health which we should know? _____
- _____
- _____
- _____

Dental Insurance: _____

Subscriber: _____ D.O.B.: _____

Employer: _____

Your ID Number: _____

Group Number: _____

Payment for service is due at the time of treatment.

We will complete your insurance form for you so that you may receive reimbursement according to the terms of your policy.

When your root canal is completed, your tooth will need a surface restoration.

Your dentist will render this service which is equally important for the preservation of your tooth.

I hereby certify that the information given by me is correct to the best of my knowledge, and I have reviewed the office privacy policy (H.I.P.A.A.) information.

Your signature _____