Endodontic Specialists

NAME/FIRST MIDDLE INITIAL LAST BIRTHDATE PHONE NUMBER

STREET ADDRESS CITY STATE ZIP

SOCIAL SECURITY # Email Address Dentist

DENTAL INSURANCE

Subscribers Name:_____Subscribers DOB:_____

Social Security #:_____EMPLOYER:_____

Insurance Name:_____I.D #:_____

Group #:_____ Relationship to subscriber:_____

PATIENT HEALTH HISTORY

Please indicate if you have had....

	Yes	No		Yes	No		Yes	No
DIABETES	☐	☐	LIVER PROBLEMS	☐	☐	Inefectious Hepatits	☐	☐
EXCESSIVE BLEEDING	☐	☐	KIDNEY PROBLEMS	☐	☐	When		
RESPIRATORY PROBLEMS	☐	☐	ALLERGIES: Penicillin	☐	☐	_____		
Asthma	☐	☐	Latex	☐	☐			
COPD	☐	☐	Other medication allergies			For Women:		
			_____			Pregnant	☐	☐
						How many weeks?		

Have you had any heart valves or joints replaced? ☐ ☐

What and when: _____

Have you ever been advised by a physician to take a premedication 1hr prior to dental appointments? ☐ ☐

What do you take and dosage: _____

Do you have a history of cancer? ☐ ☐

If so, when and are you receiving treatment for it currently?_____

Any other health conditions not listed:

_____

_____

NAME OF MEDICAL DOCTOR_____ _____

	Yes	No		Yes	No
Have you been treated by your physician in the last 60 days:	☐	☐			
If so, for....(please explain) _____			**CAN YOU USE LOCAL DENTAL ANESTHETIC**	☐	☐

_____

LIST OF MEDICATIONS AND REASON FOR TAKING:

_____

_____

_____

Signature of patient or parent/guardian: _____

Date: _____