ENDODONTIC ASSOCIATES LIMITED

Have you ever been seen in our practice __ Yes __ No

PATIENT INFORMATION

First Middle Last SS#

PATIENT NAME _____

ADDRESS _____ APT. _____

CITY _____ STATE _____ ZIP _____ COUNTY _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ BIRTHDATE _____ AGE _____

FAMILY DENTIST _____ LOCATION _____

REFERRED BY _____ LOCATION _____

PLEASE CHECK ALL THAT APPLY:

- ☐ VAGUE PAIN
- ☐ PAIN TO HOT
- ☐ PAIN TO COLD
- ☐ PAIN TO PRESSURE
- ☐ TOOTHACHE
- ☐ SPONTANEOUS PAIN
- ☐ SWELLING
- ☐ PAIN TO BITING
- ☐ NONE OF THE ABOVE

GENERAL HEALTH INFORMATION

HAS YOUR PHYSICIAN ADVISED YOU THAT YOU NEED ANTIBIOTIC PRE-MEDICATION PRIOR TO ANY DENTAL WORK? (If yes, please list medication and reason) YES NO

MEDICATION _____ REASON _____

ARE YOU CURRENTLY UNDERGOING MEDICAL TREATMENT? YES NO

(IF YES, PLEASE DESCRIBE AND LIST YOUR PHYSICIAN'S NAME)

DESCRIPTION _____

PHYSICIAN'S NAME _____

ARE YOU TAKING ANY OVER THE COUNTER OR PRESCRIPTION MEDICATIONS? YES NO

IF YES, PLEASE LIST ALL _____

_____

_____

_____

DO YOU HAVE OR HAVE YOU EVER HAD: (PLEASE CIRCLE YES OR NO FOR ALL QUESTIONS)

ABNORMAL HEART CONDITION/HEART SURGERY/PACEMAKER YES NO

If yes, please explain _____

ARTIFICIAL JOINTS AND/OR REPLACEMENT YES NO

If yes, what and how recent _____

DIABETES	YES	NO	BLOOD PRESSURE HIGH, LOW OR GESTATIONAL	YES	NO
LATEX ALLERGY	YES	NO	HEPATITIS (IF YES, TYPE _____)	YES	NO
HIV/AIDS	YES	NO	TUBERCULOSIS	YES	NO
CANCER	YES	NO	OSTEOPOROSIS	YES	NO
ASTHMA	YES	NO	BACK OR NECK PROBLEMS	YES	NO
EATING DISORDER	YES	NO	THYROID	YES	NO
CHEMICAL DEPENDENCY	YES	NO	STROKE	YES	NO
ULCERS	YES	NO			

ARE YOU ALLERGIC TO, OR HAVE YOU EVER HAD ANY UNUSUAL REACTION TO ANY DRUG OR ANESTHETIC? YES NO

If yes, please explain _____

_____

WOMEN, ARE YOU PREGNANT? If so, how many months _____ YES NO

WOMEN, ARE YOU TAKING ORAL CONTRACEPTIVES? YES NO

IS THERE ANY OTHER INFORMATION ABOUT YOUR HEALTH YOU FEEL WE SHOULD KNOW? YES NO

If yes, please explain _____

_____

(COMPLETE REVERSE SIDE OF FORM)