ENDODONTICS AND ENDODONTIC SURGERY

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18 S. Roland Street, Pottstown, Pennsylvania 19464 (610) 327-4646

Personal History

Date: _____

Patient Name

Address

City, State, Zip

Sex: Male Female

Date of Birth Social Security #

Home Phone Work Phone

Patient's Occupation

Patient's Employer

Employer's Address

City, State, Zip

Referred by

Have you ever been treated in our office before?
Yes No

If so, when? _____

FINANCIALLY RESPONSIBLE PERSON IF OTHER THAN PATIENT

Name

Address

City, State, Zip

Sex: Male Female

Date of Birth Social Security #

Home Phone Work Phone

Occupation

Employer

Employer's Address

City, State, Zip

If patient is over 18 and is a full-time student:

Name of School

City

Primary Dental Insurance

Name of Insurance Company

Address

City, State, Zip

ID # Group Name or #

Subscriber's Name on Insurance Coverage

Date of Birth Social Security #

Employer's Name

Address

What percentage will this insurance company cover? ___%

How is this employee related to the patient?
Subscriber Spouse Parent

Secondary Dental Insurance

Name of Insurance Company

Address

City, State, Zip

ID # Group Name or #

Subscriber's Name on Insurance Coverage

Date of Birth Social Security #

Employer's Name

Address

What percentage will this insurance company cover? ___%

How is this employee related to the patient?
Subscriber Spouse Parent

I agree to be responsible for any charges. 24 hour cancellation notice requires or a $25.00 fee will be charged.

Date: _____ Signature: _____

Medical History

Patient Name

General Health:
Excellent Good Fair Poor

Are you under the care of a physician?
Yes No
If yes, please explain

Name and address of family physician:

Are you wearing a pacemaker or heart valve prosthesis? Yes No

Have you been hospitalized or had a serious illness in the past 5 years?
Yes No
If yes, please explain:

Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?
Yes No

Are you taking any kind of medication (prescribed or non-prescribed) or drug at this time? Yes No

If yes, please explain:

Are you currently taking or have you taken in the past 5 years any of the following medications?

Fosamax	Boniva
Actonel	Didronel
Skelid	Aredia
Zometa	

Do you need to premedicate for dental treatment? Yes No

Are you pregnant? Yes No
How many months? _____

Have you ever undergone Root Canal Treatment? Yes No

Circle any of the following to which you're allergic or have had an unusual reaction to:

Penicillin	Aspirin	Demerol
Sulfa Drugs	Darvon	Nitrous Oxide
Erythromycin	Codeine	Steroids
Novocaine (Xylocaine)	Valium (tranquilizers)	Motrin
Sedatives & Barbiturates		

Other

Circle any of the following which you have had:

Heart Trouble	Asthma	AIDS or HIV
Heart Murmur	Cough	Venereal Disease
Rheumatic Fever	Hay Fever	Herpes
High Blood Pressure	Hives or Skin Rash	Arthritis
Angina	Diabetes	Kidney Trouble
Stroke	Tuberculosis	Radiation Therapy
Congenital Heart Disease	Psychiatric Treatment	Epilepsy
Hepatitis	Glaucoma	Ulcers
Lung Disease	Convulsions	Blood Disorders
Anemia	Sinus Trouble	Thyroid Trouble
Migraine	Fainting Spells	

Is there anything else about your health we should know?

Do you have any special needs?

What is your chief dental complaint?

Signature Date