Superior Endodontics
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Patient Information

Date _____

Patient name (first, middle initial, last) _____

What name would you prefer our staff use? _____

☐ Male ☐ Female Social Security No. _____ Occupation _____

Street Address _____ Apt # _____

City _____ State _____ Zip _____ Date of Birth _____

Home phone _____ Office phone _____ Cell phone _____

Email address _____

What is your general dentist's name? _____

Person to contact in case of emergency _____ Phone _____

Patient Information

Name of insured _____ Relationship to patient_____

Date of birth _____ Social Security No. _____

Employer _____ Date employed _____ Work phone _____

Insurance co. name _____

Group # _____ Policy ID # _____

Insurance co. address _____ City _____ State _____ Zip _____

Do you have dental insurance? ☐ Yes ☐ No *If yes, please complete the following:*

Name of insured _____ Relationship to patient_____

Date of birth _____ Social Security No. _____

Employer _____ Date employed _____ Work phone _____

Insurance co. name _____

Group # _____ Policy ID # _____

Insurance co. address _____ City _____ State _____ Zip _____

Person Responsible for Payment

Name of person responsible for payment _____ Relationship to patient _____

Street Address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email Address _____

Date of birth _____ Social Security No. _____ Drivers License No. _____

Employer _____ Work phone _____

Confidential Dental/Medical History

Please print and fill out form completely. Thank you

When was the last visit to your general dentist? _____

Chief complaint or reason for your visit today _____

Are you in pain today? ☐ Yes ☐ No Pain to cold? ☐ Yes ☐ No

Pain on biting pressure? ☐ Yes ☐ No Pain to hot foods/ liquids? ☐ Yes ☐ No

Name of physician _____ Office phone _____

Date of last exam _____ Reason for last exam _____

Your current physical health ☐ Good ☐ Fair ☐ Poor

Are you taking any medications ☐ Yes ☐ No If yes, please list _____

Are you allergic to any of the following?

Aspirin	☐ Yes ☐ No	Local anesthesia	☐ Yes ☐ No	Penicillin	☐ Yes ☐ No
Codeine	☐ Yes ☐ No	Latex	☐ Yes ☐ No	Other Antibiotics	☐ Yes ☐ No
Clindamycin	☐ Yes ☐ No	Tetracycline	☐ Yes ☐ No	Other	☐ Yes ☐ No

Please list any other drugs or materials you are allergic to _____

Are you currently taking aspirin? ☐ Yes ☐ No Have you ever been treated with Bisphophonate drugs? ☐ Yes ☐ No

If yes, list _____

Are you pregnant? ☐ Yes ☐ No Week # _____

Are you taking birth control pills? ☐ Yes ☐ No Are you a nursing mother? ☐ Yes ☐ No

Abnormal heart condition	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver disease	☐ Yes ☐ No
AIDS/HIV	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Mitral valve prolapse	☐ Yes ☐ No
Alcohol/drug abuse	☐ Yes ☐ No	Epilepsy/Seizures	☐ Yes ☐ No	Nervous disorder	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Heart attack	☐ Yes ☐ No	Psychiatric care	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart murmur	☐ Yes ☐ No	Radiation treatment	☐ Yes ☐ No
Bleeding problems	☐ Yes ☐ No	Heart valve replacement	☐ Yes ☐ No	Rheumatic fever	☐ Yes ☐ No
Blood transfusion	☐ Yes ☐ No	Heart surgery	☐ Yes ☐ No	Sinus problems	☐ Yes ☐ No
Breathing problems	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Steroid therapy	☐ Yes ☐ No
Cancer/Chemotherapy	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Colitis	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Subacute Bacterial Enddocarditis	☐ Yes ☐ No
Congenital heart defect	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No	Thyroid treatment	☐ Yes ☐ No
Defibrillator	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Joint replacement	☐ Yes ☐ No	Other	☐ Yes ☐ No

Is there any other medical condition you have not listed above? _____

Have you been hospitalized in the last five years? ☐ Yes ☐ No Reason: _____

I, the undersigned (patient or legally responsible party), authorize the taking of radiographs and/or other diagnostic measures required for a though rough and complete evaluation. I certify that I have read and understand the above and that the information submitted on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian _____ Date _____

First medical update Date: _____ Any changes? ☐ Yes ☐ No

Signature _____ Date _____