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Endodontic Innovations
13127 Kings Lake Drive, Suite 101, Gibsonton, FL 33534

Today's Date: _____

PATIENT INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other Gender: ☐ Male ☐ Female

First Name: _____ Last Name: _____ MI: _____

Birth Date: _____ Social Security Number: _____

Address: _____

City, State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____ ☐ I would like to receive correspondences via email.

Primary Dental Insurance Company Name: _____

Secondary Dental Insurance Company Name: _____

Responsible Party First Name: _____ Last Name: _____ MI: ___

Relationship to Patient: _____

APPOINTMENT INFORMATION

Reason for visit: _____

Are you experiencing any pain? ☐ YES ☐ NO

If yes, level of pain from 1-10: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

0 None 1 2 Mild 3 4 5 Moderate 6 7 8 Severe 9 10 Worst Possible Pain

How often: _____ Sensitive to: ☐ Hot ☐ Cold

Does your tooth hurt when you bite down or chew? _____

Have you had any restoration on this tooth recently? _____

EMERGENCY CONTACT INFORMATION

Contact Name: _____ Phone Number: _____

Relationship to Patient: _____

The above information is true to the best of my knowledge.

_____ _____

Signature of Patient (or Parent) Date