DIANE T. MCGINTY, D.M.D., M.S., P.A.

PATIENT INFORMATION

SONIA PENA, D.M.D., P.A.

□Mr. □Mrs. □Ms. □Dr. Name _____ First Middle Last		Preferred Name	Date
Address	City	State	Zip
Phone Numbers Home:	Work: Ext:	Cell:	
Birth Date: Age:	Soc Sec: Sex: M F	Drivers Lic:	
Patient's Occupation:	If child, parent's name:	Patient's Employer:	
General D.D.S., Name and Phone No.:	Referred by Other?	Patient's Physician and Phone No.	
Emergency Contact Name and Number		E-mail:	

DENTAL Insurance Company:	Phone Number:
Address of Insurance Co.	
Name of Insured(Primary Policy Holder):	
Relationship to Insured:	Insured Employer:
Insured SS:	Insured Birth Date:
Member ID #:	Group #:

Please present insurance card to receptionist with this information sheet.

PATIENT'S MEDICAL HISTORY

Yes	No		
□	□	Are you in good health?	
□	□	Are you under a physician's care?	
□	□	Are you subject to prolonged bleeding?	
□	□	Have you ever had major surgery?	
□	□	Have you been hospitalized in the last 5 years?	
□	□	If Female: Are you pregnant? What month? ____	
□	□	Do you have or been told you have TMJ problems?	
□	□	Are you allergic to or had an unusual reaction to an anesthetic, drug or pill? List them:_____ _____ _____	
□	□	Are you taking medications now? List them:_____ _____ _____	
□	□	Do you take oral contraceptives?	
□	□	Do you premedicate for dental treatment?	

Please check any of the following which you have had or presently have.

____ Heart Condition	____ Glaucoma
____ Angina	____ Tuberculosis
____ Heart Attack	____ Venereal Disease
____ Heart Pacemaker	____ HIV
____ Heart Murmur	____ Liver Disease
____ Congenital Heart Disease	____ Kidney Disease
____ Heart Surgery	____ Chemo/Radiation Therapy
____ Rheumatic Fever	____ Psychiatric Treatment
____ Prolapsed Mitral Valve	____ Blood Disorders
____ Diabetes	____ Respiratory, Lung Disease
____ Hepatitis	____ High Blood Pressure
____ Ulcers	____ Artificial Heart Valve
____ Stroke	____ Artificial Joint Replacement
____ Anemia	____ Cancer
____ Asthma	____ Epilepsy

Is there any other information we should know about your health?

_____

_____

_____

_____

_____

Signature of Patient, Parent, or Agent Date

DIANE T. MCGINTY, D.M.D., M.S., P.A. **PATIENT INFORMATION** SONIA PENA, D.M.D., P.A.

PERMISSION FOR ENDODONTIC PROCEDURE

I, the undersigned, consent to receive special consultation and should I agree to accept professional advice, also consent to the performing of whatever procedure may be decided upon to be necessary or advisable in the opinion of the doctors.

I also understand that only the root canal treatment is to be performed at this office. The permanent (outside) restoration (filling, inlay, crown, etc.) will be done by my regular dentist. _____ Patient Initial

Endodontic treatment has a high degree of success. As with any medical or dental treatment, however, there is no guarantee of success.

If I have a porcelain bridge or crown, I understand that there is a remote possibility of fracture or chipping of the porcelain.

Payment is due at time of treatment. If I have insurance and my insurance company does not pay for any part of my treatment for any reason, I understand that I remain responsible for all costs incurred and will make payment to this office for treatment.

If this account should become delinquent and past due, I/we agree to pay all cost of collection including, but not limited to, interest, court costs, sheriff fees, attorney fees and collection costs as may be necessary.

_____

Signature of Patient, Parent, or Agent Date