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

# PATIENT INFORMATION

FREDERICKA SALBO, D.M.D.

| | | | |
|---|---|---|---|
| □Mr. □Mrs. □Ms. □Dr.<br>Name _____<br>First Middle Last | | Nickname | Date |
| Address | City | State | Zip |
| Phone Numbers<br>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 | | Patient's 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

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## 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