East End Endodontics

4010 Dupont Circle, Suite 524 A
Louisville ,KY 40207

Patient Record Number

Confidential Information

Name: _____ Date of Birth: _____ Male _____ Female_____

Residence Address: _____

City: _____State:_____ Zip Code: _____ Patients SSN: _____

Phone Number (s): (H)_____(W)_____(C)_____(other)_____

Referring Dentist: _____ Address/Phone: _____

Family Physician: _____ Address/Phone: _____

Personal & Insurance Information

Name of Insured: _____ Relationship to patient: _____

Date of Birth of Insured: _____ Insured SSN#: _____

Name of Employer: _____ Employer Address: _____

_____City/State/Zip: _____

Insurance Company: _____ Group#: _____ ID#: _____

Insurance Co. Address: _____

City/State/Zip: _____ Insurance Co. Phone Number: _____

If you have a Secondary Insurance, please complete the following

Name of Insured: _____ Relationship to patient: _____

Date of Birth of Insured: _____ Insured SSN#: _____

Name of Employer: _____ Employer Address: _____

_____City/State/Zip: _____

Insurance Company: _____ Group#: _____ ID#: _____

Insurance Co. Address: _____

City/State/Zip: _____ Insurance Co. Phone Number: _____

Health History

Please List your current medications: _____

_____

_____

Please list any medication allergies: (i.e. dental anesthetic, antibiotics, pain medicines, latex) _____

_____

Do you require antibiotic premedication prior to dental treatment? **YES** **NO**

If you are a female, is there any chance that you are pregnant? **YES** **NO**

Please circle any of the following that you have or have ever been told that you have:

Heart attack / Angina Date (s)_____	Ulcers / Digestive trouble
Hypertension (Blood Pressure)	Migraine / Headaches
Rheumatic Fever / Heart murmur	Epilepsy / Seizures / Fainting
Artificial heart valve	Glaucoma / Vision problems
Respiratory disease / Asthma / Sinusitis	Tumors / Cancer
HIV / AIDS	Tuberculosis
Immunosuppression / Organ transplant	Venereal disease
Anemia / bleeding problems	Hormonal problems
Diabetes Blood sugar # today_____	Alcoholism / Drug addiction / Tobacco use
Psychological problems	TMD (Jaw joint problems)
Anxiety / Panic attacks	Hepatitis / Jaundice / Liver disease
Renal disease	Artificial joints Year completed_____
Stroke Date (s)_____	Arthritis
Skin disease	Thyroid disease
Vertigo / Balance problems	Hearing loss

To be filled in by Doctor:	
_____ BP:	/
_____ BP:	/
_____ BP:	/
_____ BP:	/
_____ BP:	/
_____ BP:	/
_____ BP:	/

I hereby certify that the biographical and medical information I have provided is accurate to the best of my recollection. I will decide with my doctors whether or not to proceed with treatment. I also understand that my signature below does not obligate me to any treatment and simply confirms that I have provided accurate information and have read the consent form and generally understand the anticipated root canal treatment procedure including the possible complications.

Signature: _____Date:_____

Health History