



Patient Record
Number

Confidential Information

Name: _____ Date of Birth: _____ (M) _____ (F) _____

Residence Address: _____

City: _____ State: _____ Zip Code: _____ Patients SSN: _____

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

(email) _____ Referring Dentist: _____

Referring Dentist Address/Phone: _____

Pharmacy: _____ Address/Phone: _____

Dental Insurance Information only:

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 Dental 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) _____

Hypertension (Blood Pressure)

Rheumatic Fever / Heart murmur

Artificial heart valve

Respiratory disease / Asthma / Sinusitis

HIV / AIDS

Immunosuppression / Organ transplant

Anemia / bleeding problems

Diabetes Blood sugar # today _____

Psychological problems

Anxiety / Panic attacks

Renal disease

Stroke Date (s) _____

Skin disease

Vertigo / Balance problems

Ulcers / Digestive trouble

Migraine / Headaches

Epilepsy / Seizures / Fainting

Glaucoma / Vision problems

Tumors / Cancer

Tuberculosis

Venereal disease

Hormonal problems

Alcoholism / Drug addiction / Tobacco use

TMD (Jaw joint problems)

Hepatitis / Jaundice / Liver disease

Artificial joints Year completed _____

Arthritis

Thyroid disease

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: _____