



FOREST CITY ENDODONTICS

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Patient Information Form

Patient Name: _____ Date of Birth: _____

Home Address: _____ City: _____ Postal Code: _____

Tel: H: _____ W: _____ CELL: _____ Dental Insurance: Yes No

Employer: _____ Occupation: _____

MEDICAL:

Have you had any serious illness or operation in the past? Yes No

If yes, please describe: _____

Do you have, or have you had any of the following:

Rheumatic fever, valvular heart disease or heart murmur? Yes No

Heart attack, angina, stroke?..... Yes No

High blood pressure? Yes No

Heart failure? Yes No

Chest pain, shortness of breath, ankle swelling? Yes No

Asthma or chronic cough? Yes No

Seizures or blackouts? Yes No

Hepatitis, jaundice, T.B., HIV, aids..... Yes No

Hemophilia or other bleeding abnormality? Yes No

Diabetes, thyroid, kidney or adrenal disease? Yes No

Any blood disorders? Yes No

Arthritis, or rheumatism? Yes No

Allergies? Yes No

Do you have an allergy to latex? Yes No

Pacemaker? Yes No

Are you sensitive to any medications? Yes No

Women only: Are you pregnant? Yes No

Are you taking birth control pills? Yes No

Please list any medical conditions not mentioned above that you may have:

Please list all medications that you are now taking:

DENTAL: Please list any previous conditions involved with dental treatments:

Name of person to contact in the event of emergency: _____

HOME: _____ WORK: _____ CELL: _____

Physician's name: _____ Referring Dentist's name: _____

Date: _____ Signature: _____

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