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

EMAIL: ___________________ 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:

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Please list all medications that you are now taking:

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DENTAL: Please list any previous issues with dental treatment (eg. difficulty freezing, fainting, etc):

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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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