everett endodontics

PATIENT INFORMATION & MEDICAL HISTORY

PLEASE PRINT

Have you ever been a patient in our practice? If so, when was your most recent visit? ....

PATIENT INFORMATION

Title.................... First Name.. Last Name ....

Street Address ....

City... State.......................... Zip Code ....

Home Phone ....- ....- .... Work Phone ....- .... - ....

Cell Phone................-..................- .... Email ....

Sex.................... Date of Birth............/.........../.................. SS#................-.............-....................

Occupation ....

Preferred Follow-up Contact Method ☐ Postal Mail ☐ Email

DO YOU HAVE DENTAL INSURANCE? Yes / No

Primary Subscriber Name...

Primary Subscriber Date of Birth.........../.............../...............

Relationship to Patient...

Employer.. Insurance Company..

I.D. #... Group or Plan #..

REFERRAL SOURCE

General Dentist (If Different) ....

Emergency Contact (name)... Phone #............-............-............

Patient/Guardian Signature.. Date............../............./..............

Reviewed By... Date............../............./..............

Note: If patient is under the age of 18, the signature of a parent or guardian is required.

everett endodontics

Patient Name ....

CONFIDENTIAL MEDICAL HISTORY

Name, Address and Phone Number of Physician ....

....

Are you presently under the physician's care? Yes / No

For what condition? ....

Are you currently taking **BIRTH CONTROL PILLS?** Yes / No

Are you currently taking any **MEDICATIONS? (Please list)** ....

....

Have you ever been told to take antibiotics before dental visit? Yes / No

Do you have any bleeding problems? Yes / No

Are you Pregnant or Nursing? Yes / No

Have you ever been treated for any infectious disease? Yes / No

Please indicate which of the following pertains to you (check box):

- ☐ Rheumatic Fever
- ☐ Diabetes
- ☐ Aids / HIV+
- ☐ Colitis
- ☐ Hepatitis
- ☐ Liver trouble
- ☐ Arthritis
- ☐ Joint replacement
- ☐ Bisphosphonates for osteoporosis
- ☐ Chemotherapy
- ☐ Radiation Therapy
- ☐ Kidney Disease
- ☐ Epilepsy
- ☐ Asthma
- ☐ Sinusitis
- ☐ Heart Murmur
- ☐ Tuberculosis
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Blood Disease
- ☐ Stomach Ulcers
- ☐ STD
- ☐ Other ....

Do you have allergies to any of the following (check box)?

- ☐ Novocain
- ☐ Lidocaine
- ☐ Penicillin
- ☐ Tetracycline
- ☐ Doxycycline
- ☐ Latex
- ☐ Sulfa drugs
- ☐ Aspirin
- ☐ Codeine
- ☐ Demerol
- ☐ Erythromycin
- ☐ Other ....

Patient/Guardian Signature .... Date ..../........./.........

Reviewed By .... Date ..../........./.........

Note: If patient is under the age of 18, the signature of a parent or guardian is required.