PATIENT INFORMATION (Please Print)

Title: _____ First Name: _____ MI: ____ Last Name: _____

Birthdate: _____ Soc. Sec.: _____ Gender: ○ Male ○ Female

Address: _____ Apt./Suite: _____

City: _____ State: _____ Zip Code: _____

Phones: Home: ( ) _____ Work: ( ) _____ Ext: _____

Mobile: ( ) _____ Fax: ( ) _____ Email: _____

Employer: _____ Phone: ( ) _____ Occupation: _____

Referred By: _____ General Dentist: _____

FIRST NAME LAST NAME FIRST NAME LAST NAME

Have you been seen in this practice before today? ○ Yes ○ No

PERSON RESPONSIBLE FOR ACCOUNT (if other than patient)

Title: _____ First Name: _____ MI: ____ Last Name: _____

Relationship to Patient: ☐ patient ☐ spouse ☐ child ☐ other - please specify _____ Soc. Sec.: _____

Address: _____ Apt./Suite: _____

City: _____ State: _____ Zip Code: _____

Phones: Home: ( ) _____ Work: ( ) _____ Ext: _____

Mobile: ( ) _____ Fax: ( ) _____ Email: _____

Employer: _____ Phone: ( ) _____ Occupation: _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Ins. Co. _____

Group #: _____ Phone: _____

Employer: _____

Employee (if other than patient)

Name: _____ _____

Birthdate: _____ Soc. Sec.: _____

Subscriber #: _____ Sex: ○ Male ○ Female

Secondary Insurance

Ins. Co. _____

Group #: _____ Phone: _____

Employer: _____

Employee (if other than patient)

Name: _____ _____

Birthdate: _____ Soc. Sec.: _____

Subscriber #: _____ Sex: ○ Male ○ Female

I authorize the release of any information relating to this claim and hereby direct benefits payable to the attending dentist. My co-payment is due at initiation of treatment. Any balance not paid by insurance is my responsibility.

A *notice of privacy practice* is available to me and is posted in the lobby.

_____ _____ _____ _____

Signature (parent or guardian if patient is a minor) Date Signature of authorized representative Date

Endodontic Associates

Medical History – Please answer each question.

Patient Name (please print): _____

Are you taking medication for any of the following:

1. Heart Rate:	O Yes O No	13. Pain Medications:	O Yes O No
2. Blood Pressure:	O Yes O No	14. Antibiotics:	O Yes O No
3. Blood Thinner:	O Yes O No	15. Arthritis:	O Yes O No
4. Cholesterol:	O Yes O No	16. Asthma/Breathing:	O Yes O No
5. Diabetes:	O Yes O No	17. Thyroid:	O Yes O No
6. Migraines:	O Yes O No	18. Seizures:	O Yes O No
7. Chemotherapy:	O Yes O No	19. Birth Control:	O Yes O No
8. Anti-depressant:	O Yes O No	20. Hormones:	O Yes O No
9. Anti-anxiety	O Yes O No	21. Osteoporosis:	O Yes O No
11. Sleep Aids	O Yes O No	Other: _____	
12. Herbal Medications	O Yes O No	_____	

Do you or have you had any of the following:

1. Diabetes:	O Yes O No	10. Cancer:	O Yes O No
2. Hepatitis A,B,C,D:	O Yes O No	12. Stroke:	O Yes O No
3. Thrush:	O Yes O No	13. Artificial Joint:	O Yes O No
4. Herpes:	O Yes O No	14. Tuberculosis:	O Yes O No
5. Thyroid Problems:	O Yes O No	15. AIDS/HIV:	O Yes O No
6. Pacemaker:	O Yes O No	16. Chest Pain:	O Yes O No
7. Heart murmur:	O Yes O No	17. Mitral Valve Prolapse:	O Yes O No
8. Heart attack:	O Yes O No	18. High Blood Pressure:	O Yes O No
9. Ulcer/Stomach:	O Yes O No		

Are you allergic to any of the following:

1. Penicillin:	O Yes O No	5. Codeine:	O Yes O No
2. Aspirin:	O Yes O No	6. Dental Anesthesia:	O Yes O No
3. Demerol:	O Yes O No	7. Latex:	O Yes O No
4. Sulfa Drugs:	O Yes O No	8. Other: _____	

Do you **pre-medicate** with antibiotics prior to dental treatment for an artificial joint or artificial heart valve? O Yes O No

Are there any other conditions you feel are important? O Yes O No

_____

_____

Signature of Patient or Guardian _____ Date _____

HIPAA acknowledgement and Medical Release

I, _____ authorize

Patient Name

Endodontic
ASSOCIATES, P.A.

to **release** my dental records and billing/account history to:

Name:_____

Relationship:_____

Address:_____ **Zip Code** _____

Home phone:_____

Mobile phone:_____

Email:_____

Name:_____

Relationship:_____

Address:_____ **Zip Code** _____

Home phone:_____

Mobile phone:_____

Email:_____

Patient Signature:_____ **Date :**_____