PRECISION MICROENDODONTICS

WELCOME TO OUR PRACTICE

Please fill out **all** blank spaces.

Patient:

(Mr___Mrs___ Dr___Ms___) First________________________ M.I.________ Last_______________________________________

Sex: Male_____ Female_____ Marital Status: Single_____ Married_____ Divorced_____ Widowed_____

Date of Birth: __________________ Social Security #_____-____-_____ Email Address:______________________________

Who will be responsible for account? Self ☐ Spouse ☐ Father ☐ Mother ☐ Other ☐

Home Address:

Street____ City_______________________ State________ Zip_______

Home Telephone (_____)________________________ Cell phone (_____)_________________________

Emergency Contact:

Name ____________________ Relationship: _______________________ Telephone (_____)_____________

Pharmacy Address/Phone Number: ____

Referral:

Name of Referring Dentist or Provider: _____________________ Address: ____

Name of General Dentist: ____________________ Address: ____

Primary Dental Insurance Company

Ins. Co. Name____

Address____ Telephone (____)__________________________________

ID #____Group # _____________________________________

Subscriber____ Relation____

Subscriber's Date of Birth__________________________________ Soc. Sec. #____

Primary Medical Insurance Company

Ins. Co. Name____

Address____ Telephone (_____)__________________________________

ID#____ Group#____

Subscriber____ Relation____

Subscriber's Date of Birth_____________________________ Soc. Sec. #____

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To our patients:

Although endodontists primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medications that you may be taking could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Height__________ Weight__________ Age__________

Have you had any illness, operation or been hospitalized in the past five years? ____

Is there any condition concerning your health or your family's anesthetic history that the doctor should be told? _________________________________

Do you have a prosthetic joint or valve? Yes__________ No__________

Do you smoke or chew tobacco? Yes__________ No__________

Do you consume alcoholic beverages? Yes__________ No__________

Medications: Please list all medications, drugs, pills, or herbs you are currently taking:

____

Allergies: Please list all allergies you have to medications:

____

Women:

Is there a possibility that you may be pregnant? Yes__________ No__________

Are you nursing? Yes__________ No __________

Have you had or do you currently have…	**Yes**	**No**	**Have you had or do you currently have…**	**Yes**	**No**
Prosthetic Heart Valve			Stroke		
Congenital Heart Disease			Thyroid Trouble		
Previous Endocarditis			Diabetes		
High Blood Pressure			Low Blood Sugar		
Cardiac Transplant			Kidney Trouble		
Chest Pain, Angina			Osteoporosis		
Heart Attack			Are you on Dialysis		
Irregular Heart Beat			Swollen ankles, Arthritis or Joint Disease		
Cardiac Pacemaker			Stomach Ulcer		
Heart Surgery			Contagious Disease		
Bronchitis, Chronic Cough			Problems of the Immune System		
Asthma			Sexually Transmitted Disease		
Hayfever / Sinus Problems			A tumor or Growth		
Tuberculosis			Mental Health Problems		
Emphysema			Radiation Treatment / Chemotherapy		
Difficulty Breathing			Are you wearing a removable dental appliance		
Blood Transfusion			Are you taking Bisphosphonates (Fosamax, etc.)		
Blood Disorder such as Anemia					
Convulsions / Epilepsy					
Abnormal Bleeding Tendency					
Jaundice, Hepatitis or Liver Disease					
Infectious Mononucleosis					

I certify that I have read and understand the questions above. I will not hold my surgeon or any members of his / her staff responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: ____ **Date:** _________________