PATIENT INFORMATION

Welcome to Alliance Endodontics! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient's name _____ Age_____ Preferred name _____

If minor, parents' names _____ Cell phone _____ Home phone _____

Mailing address _____ City _____State _____ Zip _____

Your Email Address_____

Which dental office may we thank for referring you to our office? _____ ❑ Phonebook

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number/ If minor, parent's SS#: _____ Patient Birth date:_____

Primary Dental Insurance Co._____ Subscriber ID#_____ Group number_____

Covered by parent/spouse's insurance? ❑ yes ❑ no

Subscriber's name _____ Subscriber's dental insurance company _____

Subscriber's Birthdate _____ Subscriber's Social Security number _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?

(Please check yes or no for each item)

❑ yes	❑ no	Cancer or tumor
❑ yes	❑ no	Heart ailment or angina
❑ yes	❑ no	Heart murmur, mitral valve prolapse, defect
❑ yes	❑ no	Rheumatic fever or rheumatic heart disease
❑ yes	❑ no	Artificial joint or valve
❑ yes	❑ no	High or low blood pressure
❑ yes	❑ no	Pacemaker
❑ yes	❑ no	Tuberculosis or other lung problems
❑ yes	❑ no	Hepatitis or other liver disease
❑ yes	❑ no	Blood disorder
❑ yes	❑ no	Diabetes/Kidney Disease
❑ yes	❑ no	Neurologic condition
❑ yes	❑ no	Epilepsy, seizures, or fainting spells
❑ yes	❑ no	Emotional condition
❑ yes	❑ no	Radiation/Chemo
❑ yes	❑ no	Arthritis
❑ yes	❑ no	Herpes or cold sores
❑ yes	❑ no	Immunocompromised
❑ yes	❑ no	Migraine headaches or frequent headaches
❑ yes	❑ no	Do you have a mental disorder?
❑ yes	❑ no	Abnormal bleeding after extractions, surgery, or trauma
❑ yes	❑ no	Any Transplant
❑ yes	❑ no	Hayfever or sinus trouble
❑ yes	❑ no	Allergies or hives
❑ yes	❑ no	Asthma
❑ yes	❑ no	I am hard to numb
❑ yes	❑ no	TMJ/TMD

Do you smoke or use chewing tobacco? ❑ yes ❑ no

ALLERGIES

Are you allergic to, or have you reacted adversely to any of the following?

❑ yes	❑ no	Latex materials
❑ yes	❑ no	Penicillin or other antibiotics
❑ yes	❑ no	Local anesthetics ("Novocain")
❑ yes	❑ no	Codeine or other narcotics
❑ yes	❑ no	Sulfa drugs
❑ yes	❑ no	Barbiturates, sedatives, or sleeping pills
❑ yes	❑ no	Nitrous
❑ yes	❑ no	Bleach
❑ yes	❑ no	Ibuprofen
❑ yes	❑ no	Food
❑ yes	❑ no	Other:_____

MEDICINES

ARE YOU CURRENTLY TAKING ANY OF THESE?

❑ yes	❑ no	Aspirin
❑ yes	❑ no	Anticoagulants (blood thinners)
❑ yes	❑ no	Antibiotics or sulfa drugs
❑ yes	❑ no	High blood pressure medicine
❑ yes	❑ no	Antidepressants or tranquilizers
❑ yes	❑ no	Insulin, Orinase, or other diabetes drug
❑ yes	❑ no	Nitroglycerin
❑ yes	❑ no	Cortisone or other steroids
❑ yes	❑ no	Osteoporosis (bone density) medicine
❑ yes	❑ no	Other:_____

_____

Women:

❑ yes	❑ no	Pregnant or May be pregnant Expected delivery date: _____
❑ yes	❑ no	Taking hormones or contraceptives

Do you have any disease, condition, or problem not listed above?_____

Signature of patient (or parent) _____ Date _____