patient information

Patient Name: _____

Phone #: _____ Cell #: _____

Email: _____

Home Address: _____

City: _____ State: _____ ZIP: _____

Soc. Sec. #: _____ Birthday: ____ / ____ / _____

Driver's License #: _____

Marital Status: _____

Employer: _____

Position: _____

Spouse's Name: _____

Spouse's Employer: _____

Person to contact in case of emergency

Name: _____ Phone #: _____

Referring Dentist

Name: _____ Phone #: _____

Your Physician

Name: _____ Phone #: _____

Other Physician

Name: _____ Phone #: _____

Name of dental insurance company: _____

Name of Subscriber: _____

Subscriber birthday: ____ / ____ / _____

I.D. #: _____

Group #: _____

craig wm. anderson, dds
endodontics
a dental corporation

medical | dental history

1. Are you now under the care of a physician for any health problems? (Y) (N)
2. Have you been hospitalized in the last year? (Y) (N)
3. Please list any drugs or medications you are taking currently:

_____ _____ _____

Have you taken or are you currently taking IV or Oral Bisphosphonate medication (for bone related problems)? (Y) (N)

Chemotherapy for bone metastasis? (Y) (N)

(e.g.: antiangiogenic or antiresorptive drugs)

Cortisone Medication: (Y) (N)

4. Have you ever had to pre-medicate with antibiotics prior to your dental appointment? (Y) (N)

If so, for what medical condition? _____

5. Are you allergic to Latex, or to any other medication? (Y) (N)

(e.g.: Penicillin, Novocaine, Codeine, Adrenaline, Aspirin, etc.)

6. Drug or Alcohol Addiction? (Y) (N)
7. Have you ever had any of the following:

Heart Ailments: (Y) (N)

Pacemaker: (Y) (N)

Stroke (cerebrovascular accident): (Y) (N)

Mitral Valve Prolapse: (Y) (N)

Is it with or without regurgitation? _____

Rheumatic Fever: (Y) (N)

High Blood Pressure: (Y) (N)

If known, what is your usual blood pressure? _____

TB or Respiratory Diseases: (Y) (N)

Sinus Problems: (Y) (N)

Fainting or Dizziness: (Y) (N)

Nervous Disorders: (Y) (N)

Epilepsy or Seizures: (Y) (N)

Muscular Disorders: (Y) (N)

Diabetes: (Y) (N)

Type I or Type II? _____

If known, what is your usual blood sugar level? _____

Is it controlled? (Y) (N)

Excessive Bleeding: (Y) (N)

Are you taking "blood thinners" or anticoagulation medication? (Y) (N)

Blood Diseases: (Y) (N)

HIV or AIDS: (Y) (N)

If known, what is your CD4 (T-Cell) count? _____

Hepatitis: (Y) (N)

If so, what type? _____

Liver Disease: (Y) (N)

Kidney Disorder: (Y) (N)

Urinary Disorder: (Y) (N)

Tumors or Growths: (Y) (N)

History of Cancer: (Y) (N)

Complications of Healing: (Y) (N)

Ulcers or Gastrointestinal Disorders: (Y) (N)

Diverticulitis/IBS: (Y) (N)

Crohn's Disease: (Y) (N)

Artificial Joint or Heart Valve: (Y) (N)

If so, when was it placed? _____

Rheumatoid Arthritis: (Y) (N)

Women: Are you pregnant? (Y) (N)

If so, what trimester? _____

DENTAL HISTORY

8. Do you have a history of being difficult to numb for dental treatment? (Y) (N)
9. Do you have a tooth ache? (Y) (N)
10. Can you locate the specific tooth? (Y) (N)
11. Circle any of the following that cause pain: **Hot** **Cold** **Biting** **Sweets** **Unprovoked Pain**
12. When did the pain or swelling begin? _____
13. Is there a history of facial trauma? (Y) (N)

When?: _____

Root canal treatment is an attempt to retain a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery, or even extraction.

I, the undersigned, being the patient, guardian or parent acknowledge this information above to be true and correct.

SIGNATURE DATE

Health history update

Month:_____ YEAR:_____ Patient Initial: _____