ENDODONTICS, P. A.

888 Bestgate Road • Suite 220
Annapolis, MD 21401
(410) 224-6150
Fax (410) 224-6136

PERSONAL HISTORY

DATE

PATIENT'S NAME (PLEASE PRINT)

ADDRESS

CITY

STATE ZIP

MARITAL STATUS: ❒ SINGLE ❒ MARRIED ❒ WIDOWED ❒ SEPARATED ❒ DIVORCED

SEX: ❒ MALE ❒ FEMALE

PATIENT'S AGE DATE OF BIRTH

HOME PHONE NO. WORK PHONE NO.

SOC. SECURITY NO.

DRIVER'S LIC. NO.

PATIENT'S OCCUPATION

PATIENT'S EMPLOYER

EMPLOYER'S ADDRESS

REFERRED BY DR.

Have you ever been treated in our office before? ❒ YES ❒ NO

IF SO, WHEN?

IN CASE OF EMERGENCY, NOTIFY

PHONE NO. RELATIONSHIP

FINANCIALLY RESPONSIBLE PERSON IF OTHER THAN PATIENT

NAME (FIRST, M.I., LAST)

ADDRESS

CITY

STATE ZIP

SEX: ❒ MALE ❒ FEMALE

DATE OF BIRTH SOCIAL SECURITY NO.

HOME PHONE NO. WORK PHONE NO.

OCCUPATION

EMPLOYER

ADDRESS

CITY

ST ZIP

PATIENT'S EMAIL ADDRESS

CHART NO.

DOCTOR

REF. DOCTOR

Please complete both sides of this form.

PRIMARY DENTAL INSURANCE

NAME OF INSURANCE CO.

PHONE NO.

ADDRESS

CITY ST ZIP

ID/AGREEMENT NO. GROUP NAME OR NO.

SUBSCRIBER'S NAME ON INSURANCE COVERAGE (if different from patient)

DATE OF BIRTH SOCIAL SECURITY NO.

EMPLOYER'S NAME

ADDRESS

HOW IS PATIENT RELATED TO THE SUBSCRIBER?
❒ SPOUSE ❒ DEPENDENT

DATE _____

SECONDARY DENTAL INSURANCE

NAME OF INSURANCE CO.

PHONE NO.

ADDRESS

CITY ST ZIP

ID/AGREEMENT NO. GROUP NAME OR NO.

SUBSCRIBER'S NAME ON INSURANCE COVERAGE (If different from patient)

DATE OF BIRTH SOCIAL SECURITY NO.

EMPLOYER'S NAME

ADDRESS

HOW IS PATIENT RELATED TO THE SUBSCRIBER?
❒ SPOUSE ❒ DEPENDENT

What percentage will this Insurance Co. cover? _____ %

Signature _____

Fill out information to the left ONLY if you have dental insurance

OVER ➢

PATIENT'S NAME (please print)

1. General Health:
❒ Excellent ❒ Good ❒ Fair ❒ Poor

2. Are you under the care of a physician?
❒ Yes ❒ No

If yes, please explain: _____

3. Name and address of family physician:

4. Are you wearing a pacemaker or heart valve prosthesis? ❒ Yes ❒ No

5. Have you been hospitalized or had a serious illness in the past five years? ❒ Yes ❒ No

If yes, please explain: _____

6. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?
❒ Yes ❒ No

7. Are you taking *any* kind of medication (prescribed or non-prescribed) or drug at this time?
❒ Yes ❒ No

If yes, please explain: _____

8. Are you pregnant? ❒ Yes ❒ No

If yes, how many months? _____

9. Have you ever undergone Endodontic Treatment? ❒ Yes ❒ No

Check any of the following to which you're allergic or have had an unusual reaction to:

❒ Penicillin	❒ Aspirin	❒ Demerol
❒ Sulfa Drugs	❒ Darvon	❒ Nitrous Oxide
❒ Erythromycin	❒ Codeine	❒ Steroids
❒ Novacaine (Xylocaine)	❒ Valium (tranquilizers)	❒ Ibuprofen
❒ Sedatives & Barbituates	❒ Latex	❒ Nickel
❒ Other _____		

Check any of the following which you have had:

❒ HIV+	❒ Sinus Trouble	❒ Glaucoma
❒ Hepatitis	❒ Anemia	❒ Thyroid Trouble
❒ Heart Trouble	❒ Asthma	❒ Fainting Spells
❒ Heart Murmur	❒ Cough	❒ Venereal Disease
❒ Rheumatic Fever	❒ Hay Fever	❒ Herpes
❒ High Blood Pressure	❒ Hives or Skin Rash	❒ Arthritis
❒ Angina	❒ Diabetes	❒ Kidney Trouble
❒ Stroke	❒ Tuberculosis	❒ Radiation Therapy
❒ Congenital Heart Disease	❒ Epilepsy	❒ Psychiatric treatment
❒ Ulcers or Lung Disease	❒ Migraine	

Is there anything else about your health we should know? _____

What is your chief dental complaint? _____

Signature _____ Date _____