PARKSIDE ENDODONTICS

NAME____BIRTH DATE_______________________
(LAST, FIRST, MIDDLE INITIAL)

ADDRESS_______________________________CITY_____________________ZIP_______________

HOME PHONE _______________________CELL PHONE____________________________________
BUSINESS PHONE_____________________ EMPLOYER_____________________________________
NAME OF SPOUSE (OR PARENT)____
REFERRING DENTIST____
YOUR PHYSICIAN____
NAME OF DENTAL INSURANCE____
S.S. NO. OF INSURED___________________INSURANCE GROUP & POLICY NO.__________________
BIRTH DATE OF INSURED____

PLEASE COMPLETE THE FOLLOWING

	YES	NO
1. HEART DISEASE, HEART ATTACK, OR HEART MURMUR	☐	☐
2. CHEST PAIN OR ANGINA PECTORIS	☐	☐
3. RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE	☐	☐
4. HIGH BLOOD PRESSURE	☐	☐
5. STROKE	☐	☐
6. HEART SURGERY	☐	☐
7. PACE MAKER	☐	☐
8. JOINT SURGERY OR PROSTHETIC JOINT REPLACEMENT	☐	☐
9. DIABETES	☐	☐
10. EYE DISEASE	☐	☐
11. FAINTING SPELLS, CONVULSIONS OR EPILEPSY	☐	☐
12. HEPATITIS OR LIVER DISEASE	☐	☐
13. AIDS, ARC OR HIV DISEASE	☐	☐
14. LUNG DISEASE (T.B., ASTHMA OR OTHER)	☐	☐
15. KIDNEY DISEASE	☐	☐
16. RADIATION THERAPY OR CHEMOTHERAPY	☐	☐
17. PROLONGED BLEEDING OR SLOW CLOTTING TIME	☐	☐
18. HAVE YOU EVER TAKEN PHEN-FEN OR REDUX	☐	☐
19. ARE YOU OR COULD YOU BE PREGNANT?	☐	☐
20. ARE YOU CURRENTLY TAKING OR HAVE YOU PREVIOUSLY TAKEN BISPHOSPHONATES, SUCH AS ACTONEL, FOSAMAX OR ZOMETA?	☐	☐

21. ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

	YES	NO
NOVACAINE, LIDOCAINE OR ANY DENTAL ANESTHETIC	☐	☐
PENICILLIN	☐	☐
ASPIRIN	☐	☐
CODEINE	☐	☐
LATEX	☐	☐

OTHER____

22. ANYTHING IMPORTANT IN YOUR MEDICAL HISTORY THAT HAS NOT BEEN ASKED?

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23. LIST MEDICATIONS YOU ARE PRESENTLY TAKING, INCLUDING HERBAL MEDICATIONS.

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I HAVE COMPLETELY AND ACCURATELY ANSWERED EVERY QUESTION TO THE BEST OF MY KNOWLEDGE. I WILL INFORM THE DOCTOR OF ANY CHANGE IN MY HEALTH AND/OR MEDICATIONS.
I UNDERSTAND THAT THE TOTAL PAYMENT OF THE FEE FOR DENTAL SERVICES IS MY RESPONSIBILITY AND NOT THAT OF THE INSURANCE COMPANY. AS A COURTESY, THIS OFFICE WILL SUBMIT A CLAIM TO MY INSURANCE COMPANY.

PATIENT SIGNATURE________________________DR. SIGNATURE_____________________________

DATE___________