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 ____________