North Penn Endodontics

Patient Information

Today's Date _____

Name_____
Last First M.I.

Ms., Miss, Mrs., Mr., Dr., Fr., Sr., Rev.

Birthdate_____/_____/_____ Age_____

Home Address

_____

_____

_____

Cell # _____

Home/Other # _____

Work # _____ Ext: _____

Employer_____

Occupation_____

Emergency Contact

Name _____

Phone # _____

Relation _____

Current Dentist _____

Dental Insurance (Primary)

Dental Insurance Name (Primary)

_____

Group # (Plan, Local or Policy #)

_____

Policy Holder's Name _____

Relation _____

Policy Holder's Birthdate_____/_____/_____

Dental Insurance (Secondary)

Dental Insurance Name (Secondary)

_____

Group # (Plan, Local or Policy #)

_____

Policy Holder's Name _____

Relation _____

Policy Holder's Birthdate_____/_____/_____

Signature of Patient or Guardian _____ Date _____

Print Name _____

MEDICAL HISTORY

Do you have a personal physician?_____ Yes _____ No

Physician's Name _____

Phone # _____

Your current physical health is: ____Good ____ Fair ____ Poor

Are you being treated for any medical problems?

_____ Yes____ No

If so, please explain:

_____

_____

_____

Please list any medication that you are currently taking:

_____

_____

_____

Are you pregnant? ____ Yes ____ No

* ARE YOU REQUIRED TO TAKE ANTIBIOTICS PRIOR TO VISITS DUE TO HEART PROBLEMS OR PROSTHETIC JOINTS? ____ No ____ Yes

If Yes With What Medication? _____

Are you Allergic to the following? (Please Circle)

Amoxicillin
Aspirin
Bactrim
Barbiturates
Cephalosporin (Keflex)
Clindamycin
Codeine
Darvocet
Dexamethasone
Epinephrine
Erythromycin
Flagyl
Iodine
Latex
Penicillin
Steroids
Sulfa
Tetracycline
Vicodin

Any Other:_____

Have you ever had any of the following diseases or medical problems? (please Circle)

Abnormal Bleeding
Alcohol Abuse
Anemia
Arthritis
Artificial Bones/ Joints
Artificial Valves
Asthma
Blood Transfusion
Cancer
Chemotherapy
Colitis
Congenital Heart Defect
Coronary Artery Disease
Diabetes
Difficulty Breathing
Drug Abuse
Emphysema
Epilepsy
Fainting Spells
Fever Blisters
Fibromyalgia
Hayfever
Hemophilia
Hepatitis
Heart Attack
Heart Murmur
Heart Palpitations
Heart Surgery
Herpes
High Blood Pressure
HIV/Aids
Hospitalized for Any Reason
Kidney Problems
Liver Disease
Low Blood Pressure
Lupus
Mitral Valve Prolapse
Pacemaker
Persistent Cough
Psychiatric Problems
Radiation Therapy
Rheumatic Fever
Scarlet Fever
Seizures
Sickle Cell Disease
Shingles
Sinus Problems
Steroid Therapy
Stroke
Thyroid Disease
Transplant Surgery
Tuberculosis (TB)
Ulcers
Venereal Disease

Other:_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

_____

Signature Date

_____

Doctor Signature Date