Boston Endodontics

PATIENT INFORMATION

Name: _____

Nickname: _____ ❑ Male ❑ Female

Birth Date: _____ SS#_____

Street: _____

City: _____ State: _____ Zip: _____

Telephone numbers in the order you would like to be contacted:

Tel #1: _____ ❑ Home ❑ Cell ❑ Work ❑ Other _____

Tel #2: _____ ❑ Home ❑ Cell ❑ Work ❑ Other _____

Tel #3: _____ ❑ Home ❑ Cell ❑ Work ❑ Other _____

E-mail: _____

Employer: _____ Occupation: _____

General Dentist: _____ Tel: _____

Referring Dentist: _____ Tel: _____

If under 18, Person Responsible for Payment: (*The parent that presents the child for their appointment is financially responsible for the child's account*.)

Name: _____

Birth Date: _____ Age: _____ SS #: _____

Street: _____

City: _____ State: _____ Zip: _____

Emergency Contact (if same as above, skip to next section)

Name: _____ Relation: _____

Home Tel: _____ Cell: _____

Pharmacy Information:

Pharmacy name: _____

Pharmacy phone #: _____

PRIMARY DENTAL INSURANCE COMPANY

Subscriber Name: _____

Sex: ❑ Male ❑ Female Relation: _____

SS# /Subscriber ID #_____ DOB: _____

Employer/School: _____

Ins Carrier: _____ Ins Tel: _____

Ins Address: _____

SECONDARY DENTAL INSURANCE COMPANY

Subscriber Name: _____

Sex: ❑ Male ❑ Female Relation: _____

SS#/Subscriber ID#: _____ DOB: _____

Employer/School: _____

Ins Carrier: _____ Ins Tel: _____

Ins Address: _____

MEDICAL HISTORY

Physician's Name: _____

Phone #: _____ Last Visit Date: _____

Are you currently in good health? ❑ Yes ❑ No

Are you currently under the care of a Physician, other than routine visits? ❑ Yes ❑ No If yes please explain: _____

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N	
❑	❑	Abnormal bleeding	❑	❑	Hepatitis
❑	❑	Anemia	❑	❑	Herpes / Shingles
❑	❑	Asthma	❑	❑	High Blood Pressure
❑	❑	Arthritis / Joint Disease	❑	❑	HIV / AIDS
❑	❑	Cancer	❑	❑	Irregular Heart Beat
❑	❑	Cardiac Pace Maker	❑	❑	Joint Replacement
❑	❑	Chest Pain / Angina	❑	❑	Kidney Problems
❑	❑	Diabetes	❑	❑	Low Blood Pressure
❑	❑	Difficulty breathing	❑	❑	Mental Health Issues
❑	❑	Drug/Alcohol Abuse	❑	❑	Mitral Valve Prolapse
❑	❑	Emphysema	❑	❑	Osteopenia / Osteoporosis
❑	❑	Epilepsy / Convulsions	❑	❑	Radiation / Chemotherapy
❑	❑	Fainting Spells	❑	❑	Rheumatic Fever
❑	❑	Glaucoma	❑	❑	Severe Headaches
❑	❑	Heart Attack *(s)*	❑	❑	Sinus Problems
❑	❑	Heart Disease	❑	❑	Stomach Ulcers
❑	❑	Heart Murmur	❑	❑	Thyroid Trouble
❑	❑	Heart Surgery	❑	❑	Tuberculosis

Please list any other medical condition(s) you have ever had:

_____

Are you allergic to or ever had a reaction to:

Y	N		Y	N		Y	N	
❑	❑	Aspirin	❑	❑	Erythromycin	❑	❑	Penicillin
❑	❑	Amoxicillin	❑	❑	Latex	❑	❑	Tetracycline
❑	❑	Codeine	❑	❑	Local Anesthetic	❑	❑	Other

Please list any other allergy: _____

_____

Are you taking any prescriptions or over-the-counter medication?

❑ **Yes** ❑ **No** If yes, please list each one: _____

_____

_____

Are you required to take antibiotics prior to any dental procedures due to a medical condition? ❑ Yes ❑ No

1-4 below for women only:

1) Are you taking birth control pills? ❑ Yes ❑ No

2) Is there a possibility of pregnancy? ❑ Yes ❑ No

3) Expected Delivery date: _____

4) Are you nursing? ❑ Yes ❑ No

I understand that it is my responsibility to inform this office of any changes in my medical history.

Signature: _____ Date: _____