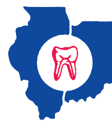

Illiana Endodontics, Inc.

MEDICAL AND DENTAL HISTORY

Patient's Name ____________________ Birth Date __________ SS# ____________

Spouse's Name ____________________ Birth Date __________ SS# ____________

Residence Address ____________________ City __________ State ____ Zip ________

Home Phone (____)__________ Cell Phone (____)__________ Work Phone (____)__________ Present Position __________

Insured Name ____________________ Birth Date __________ SS# ____________

Business Name ____

Business Address ____________________ City __________ State ____ Zip ________

Insurance Co. Name & Telephone # ____________________ (____)__________

Insurance Co. Address ____________________ City __________ State ____ Zip ________

Marital Status ____________________ Who Will Pay This Account ____________________

In Case of Emergency, Who Should Be Notified ____________________ TEL: (____)__________

Who Is Your Dentist ____________________ Patient For How Long? __________ Referred By __________

Who Is Your Physician ____________________ Date of Last Visit __________

Any Important Findings ____

May We Request Your Health Records If Necessary ___ Yes ___ No

Are You In Any Discomfort At The Present Time ___ Yes ___ No

Please State Your Reason For This Visit ____

Have You Ever Been Told That You Had:

- A.I.D.S. (HIV Positive, or ARC) ☐ Yes ☐ No
- Anemia ☐ Yes ☐ No
- Circulatory Trouble ☐ Yes ☐ No
- Diabetes ☐ Yes ☐ No
- Epilepsy ☐ Yes ☐ No
- Gall Bladder Problems ☐ Yes ☐ No
- Heart Murmur (Mitral Valve Prolapse) ☐ Yes ☐ No
- Heart Trouble ☐ Yes ☐ No
- Joint Replacement ☐ Yes ☐ No
- Hepatitis ☐ Yes ☐ No
- High Blood Pressure ☐ Yes ☐ No
- Radiation Treatment ☐ Yes ☐ No
- Rheumatic Fever or Scarlet Fever ☐ Yes ☐ No
- Stomach or Intestinal Problems ☐ Yes ☐ No
- Tuberculosis ☐ Yes ☐ No
- Venereal Disease ☐ Yes ☐ No
- Any Serious Illness Not Listed ☐ Yes ☐ No
- Ever Been Hospitalized ☐ Yes ☐ No

Are You Allergic To:

- Penicillin ☐ Yes ☐ No
- Codeine ☐ Yes ☐ No
- Local Anesthetics ☐ Yes ☐ No
- Latex ☐ Yes ☐ No
- Medication or Drugs ☐ Yes ☐ No

Are You Under The Care of A Physician ☐ Yes ☐ No

Do You Take Any Medications ☐ Yes ☐ No

If Yes
List ____
____
____

Do You Smoke or Chew Tobacco ☐ Yes ☐ No

Do You Consume More Than 3 oz. of Alcohol Per Day ☐ Yes ☐ No

Do You Now Or Have You Ever Taken Fen-Phen ☐ Yes ☐ No

Do You Now Or Have You Ever Taken Narcotics (drugs) ☐ Yes ☐ No

If Female, Are You Now:

- Pregnant ☐ Yes ☐ No
- Taking Anti-Pregnancy Drug ☐ Yes ☐ No

Have You Ever Had Endodontic Treatment (Root Canal) ☐ **Yes** ☐ **No**

____
Signature

____
Today's Date