Shore Endodontics

Today's Date_____

GETTING TO KNOW YOU

Patient Name: **Social Security Number:** **Home Phone:**

Street Address : **City, State, Zip:**

Cell Phone: **May we send you text message?** **Email:**

Yes **No**

Date of Birth: **Status:** **Child** **Single**

Male **Female** **Married** **Divorced** **Widow**

Occupation: **Employer:** **Employer Phone Number:**

Person Responsible for Account if other than yourself

Name: **Relationship:** **Home Phone:**

Address: **City, State, Zip:** **Social Security Number:**

Referred by:

MEDICAL HISTORY

Y	N	Anemia	Y	N	Head Injury	Y	N	Pacemaker
Y	N	Arthritis	Y	N	Heart Disease	Y	N	Radiation Therapy
Y	N	Artificial Joints	Y	N	Heart Murmur	Y	N	Respiratory Problem
Y	N	Asthma	Y	N	Hepatitis Type _____	Y	N	Sexually Transmitted Disease
Y	N	Blood Disorder	Y	N	Herpes	Y	N	Sinus Trouble
Y	N	Cancer	Y	N	High/Low Blood Pressure	Y	N	Stomach Problem
Y	N	Chemotherapy	Y	N	HIV/AIDS	Y	N	Stroke
Y	N	Diabetes	Y	N	Kidney Disease	Y	N	Thyroid
Y	N	Drug/Alcohol Addiction	Y	N	Liver Disease	Y	N	Tuberculosis or Lung Disease
Y	N	Epilepsy/Seizures	Y	N	Mental Disorder	Y	N	Tumor or Malignancy
Y	N	Fainting Spells	Y	N	Mitral Valve Prolapse (MVP)	Y	N	Ulcer
Y	N	Hay Fever	Y	N	Nervous Disorder			***Women***
						Y	N	Nursing or Pregnant

Y N I have consumed alcohol within the last 24 hrs.

Y N I smoke or use tobacco. If yes, how much per day?_____ How many years? _____

Y N I have had major surgery: Year _____ Type _____ Year _____ Type _____

Y N I usually pre-medicate with antibiotic prior to dental treatment. Which Antibiotic? _____

Y N Taking (please circle) Daily Aspirin Vitamin D Fish Oil Blood Thinner

Y N Do you have any other medical problem or medical history NOT listed on this form? _____

ALLERGIES

Y	N	Aspirin
Y	N	Ibuprofen
Y	N	Sulfa Drugs
Y	N	Penicillin/Amoxicillin
Y	N	Codeine
Y	N	Latex
Y	N	Local Anesthetics (Novacaine)
Y	N	Other Medications – Which ones?

_____ _____

_____ _____

Medications (Prescribed/Over the counter

Y N Attached list of medications (if yes, no need to complete below)

Medicine _____ Dosage_____ Condition_____

Medicine _____ Dosage_____ Condition_____

Medicine _____ Dosage_____ Condition_____

Medicine _____ Dosage_____ Condition_____

Medicine _____ Dosage_____ Condition_____

Medicine _____ Dosage_____ Condition_____

Medicine _____ Dosage_____ Condition_____

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Today's Date_____

In Case Of Emergency please contact

Name:	**Relationship:**	**Phone:**
Name :	**Relationship:**	**Phone:**

Dental Insurance Information Primary

Insurance Co. Name:	**Group Name:**		**Group Number:**
Insurance Co. Claim Address: **Street/PO Box:**		**City, State, Zip:**	
Subscriber's Name:	**Social Security # or ID #**	**Relationship:**	**Date of Birth:**
Subscriber's Employer:	**Employers Address:**	**Street/PO Box**	**City, State, Zip**

Dental Insurance Information Secondary (If applicable)

Insurance Co. Name:	**Group Name:**		**Group Number:**
Insurance Co. Claim Address: **Street/PO Box:**		**City, State, Zip:**	
Subscriber's Name:	**Social Security # or ID #**	**Relationship:**	**Date of Birth:**
Subscriber's Employer:	**Employers Address:**	**Street/PO Box**	**City, State, Zip**

Authorization

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need.

_____

Signature Date

PAYMENT or Estimated Co-Insurance

(whichever is applicable)

IS DUE AT TIME OF SERVICE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I certify that I or my dependent has active dental coverage with the above listed insurance companies. I am authorizing the release of information concerning my or my dependent's dental care, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits.
I consent to the direct payment of my insurance benefits to dentist or dental group and *understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.*

_____

Signature Date