Endodontics of the Hudson Valley

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Patient

First Name _____ M.I _____ Last Name _____

Home Phone _____ Date of Birth _____ SSN# ____-____-____

Address _____ City _____ State _____ Zip _____

Employer _____ Work/ Cell Number _____

Referring Dentist _____ Pharmacy _____

Physician _____ Physician's Number _____

Emergency Contact _____ Phone Number _____

Dental Insurance

Policy _____ Group Number _____

Subscriber's Name _____ Date of Birth _____

Insurance ID or SSN of Subscriber _____ Relationship _____

*Have you ever had any reaction to dental anesthetic/ Epinephrine? Yes____ No____

*Have you been hospitalized within the last 2 years? Yes____ No____

If yes, please explain: _____

*Do you have a sensitivity to Latex? Yes____ No____

*Have you ever experienced any abnormal bleeding? Yes____ No____

*Do you have to Pre-medicate before dental procedures? Yes____ No____

*Have you had a reaction to any medications? Yes____ No____

If yes, Which ones? _____

What type of reaction? _____

Please **CIRCLE** any of the following which you have presently or had in the past:

High Blood Pressure	Kidney Disease	Hepatitis
Low Blood Pressure	Liver Disease	Tuberculosis
Heart Murmur	Ulcers	AIDS/HIV
Rheumatic Fever	Diabetes	Neurological Problems
Mitral Valve Prolapse	Asthma	Psychiatric Problems
Irregular Heart Beat	Sinus Problems	Cancer_____
Pacemaker	Arthritis	Chemotherapy
Stroke	Chronic Cold Sores	Joint/ Hip Replacement
Epilepsy	Glaucoma	Sexually Transmitted Disease
Nervousness (Panic Attacks)	Thyroid Problems	Other: _____

Please list ALL medications that you are currently taking: _____

WARNING: Failure to Disclose any past/present medical conditions may adversely affect you care.

Signiture _____ Date _____

Reviewed By, With patient _____ Date _____