East Endodontic
DENTAL SPECIALISTS

First Name _____Last Name _____DOB_____
Address _____ City _____ State _____ Zip _____
Home # _____Cell #_____ Work # _____ Preferred ☐ Home ☐ Cell ☐ Work
Social Sec No _____Email _____Who will pay this account? _____
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced Sex ☐ Male ☐ Female
Employer & Address _____Current Position_____
Referring Dentist _____General Dentist_____
Preferred Pharmacy Name and Address_____

Dental Insurance Information

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Insurance Company _____	Insurance Company _____
Policy/ID# _____ Group # _____	Policy/ID# _____ Group # _____
Insured's Name _____	Insured's Name _____
Insured's Date of Birth ___/___/_____ SSN _____	Insured's Date of Birth ___/___/_____ SSN _____
Employer _____ Phone _____	Employer _____ Phone _____
Relationship to Patient _____	Relationship to Patient _____

Medical History

Are you having any discomfort at this time?	Yes	No
Are you nervous about having dental treatment?	Yes	No
Have you been hospitalized within the past two years?	Yes	No
Have you been under a doctor's care during the last two years?	Yes	No
Have you taken any medicine or drugs during the past two years?	Yes	No

Do you regularly Premedicate with an antibiotic prior to dental treatment (due to joint replacement or heart condition) Y N

Have you had or presently have one of the following conditions? Please circle Y or N

High/Low Blood Pressure	Y N	Mental Disorder	Y N	Stroke	Y N	Seasonal Allergy	Y N
Heart Murmur	Y N	Lung Disease	Y N	Diabetes	Y N	Fainting	Y N
Prolonged Bleeding	Y N	Tuberculosis	Y N	Asthma	Y N	Tumors	Y N
Blood Transfusions	Y N	Severe Infections	Y N	Hepatitis	Y N	Jaundice	Y N
Heart Valve Defect	Y N	Prosthetic Joint	Y N	Thyroid Disease	Y N	Kidney Disease	Y N
Heart Valve Prolapse	Y N	Heart Disease	Y N	Liver Disease	Y N	Other (specify)_____	
Mitral Valve Prolapse	Y N	Rheumatic Fever	Y N	Cancer	Y N		

Do you have a medical history of any infections disease (e.g. Hepatitis, AIDS, etc) Yes No
Are you taking any medication at this time? If yes, please list medication names below:
_____

Have you ever had any unusual or allergic reaction to any of the following? Please circle Y or N

Dental Local Anesthetics	Y N	Penicillin	Y N	Latex Allergy	Y N	Other (specify)_____
Aspirin Compounds	Y N	Tetracyclines	Y N	Barbiturates	Y N	
Codeine Compounds	Y N	Sulfa Drugs	Y N	Erythromycin	Y N	

WOMEN: Are you pregnant? Y N If yes, how many months? _____Due Date_____
Are you practicing birth control? Y N

Patient Signature _____ Date _____
(If patient is under the age of 18, the signature of a parent or guardian is required)