



CITY ENDODONTICS P.L.L.C.

PATIENT INFORMATION

LAST NAME	FIRST NAME	INITIAL	DATE
SOCIAL SECURITY NO.	BIRTHDATE		
ADDRESS	CITY	STATE	ZIP
HOME PHONE	MOBILE PHONE	EMAIL ADDRESS	
SEX <input type="radio"/> Male <input type="radio"/> Female	<input type="radio"/> Minor <input type="radio"/> Single	<input type="radio"/> Married <input type="radio"/> Long-Term Partner	<input type="radio"/> Divorced <input type="radio"/> Separated <input type="radio"/> Widowed
EMPLOYER	OCCUPATION		
EMPLOYER ADDRESS	CITY	STATE	ZIP
BUSINESS PHONE			
IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?	PHONE		

PRIMARY INSURANCE

LAST NAME <i>(Person responsible for account)</i>	FIRST NAME	INITIAL	
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	BIRTHDATE	
ADDRESS	CITY	STATE	ZIP
HOME PHONE	INSURED EMPLOYED BY	BUSINESS PHONE	
INSURANCE COMPANY			
INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP
SUBSCRIBER ID NO.	GROUP NO.		

ADDITIONAL INSURANCE

LAST NAME <i>(Of insured)</i>	FIRST NAME	INITIAL	
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	BIRTHDATE	
ADDRESS	CITY	STATE	ZIP
HOME PHONE	INSURED EMPLOYED BY	BUSINESS PHONE	
INSURANCE COMPANY			
INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP
SUBSCRIBER ID NO.	GROUP NO.		

DENTAL HISTORY

CURRENT DENTIST

CITY

STATE

ZIP

Please check all that apply:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Lip or Cheek Biting | <input type="checkbox"/> Sensitivity to Cold | <input type="checkbox"/> Jaw, Head or Neck Injuries |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose Teeth or Broken Fillings | <input type="checkbox"/> Sensitivity to Heat | <input type="checkbox"/> Jaw Difficulty: Clicking or Pain |
| <input type="checkbox"/> Blisters on Lips or Mouth | <input type="checkbox"/> Orthodontic Treatment | <input type="checkbox"/> Sensitivity to Sweets | <input type="checkbox"/> Tooth Pain |
| <input type="checkbox"/> Fingernail Biting | <input type="checkbox"/> Pain Around Ear | <input type="checkbox"/> Sensitivity to Biting | |
| <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Frequent Headaches | |

MEDICAL HISTORY

PHYSICIAN'S NAME

DATE OF LAST VISIT

- | | |
|---|--|
| <p>1 Are you currently under medical treatment?.....<input type="radio"/> Yes <input type="radio"/> No</p> <p>2 Have you ever had any serious illness or operations?<input type="radio"/> Yes <input type="radio"/> No</p> <p>3 Are you currently taking any medication?.....<input type="radio"/> Yes <input type="radio"/> No
<i>Please describe:</i>
.....</p> <p>4 Do you smoke?<input type="radio"/> Yes <input type="radio"/> No</p> <p>5 Do you use alcohol, cocaine or other drugs?.....<input type="radio"/> Yes <input type="radio"/> No</p> <p>6 Do you wear contact lenses?<input type="radio"/> Yes <input type="radio"/> No</p> | <p>7 Have you had any allergic reactions to the following:</p> <p>Local Anesthetics (e.g. Novocaine)<input type="radio"/> Yes <input type="radio"/> No</p> <p>Penicillin or Other Antibiotics.....<input type="radio"/> Yes <input type="radio"/> No</p> <p>Sulfa Drugs<input type="radio"/> Yes <input type="radio"/> No</p> <p>Barbiturates (Sleeping Pills)<input type="radio"/> Yes <input type="radio"/> No</p> <p>Sedatives<input type="radio"/> Yes <input type="radio"/> No</p> <p>Iodine.....<input type="radio"/> Yes <input type="radio"/> No</p> <p>Aspirin.....<input type="radio"/> Yes <input type="radio"/> No</p> <p>Other.....<input type="radio"/> Yes <input type="radio"/> No</p> <p>8 (Women Only) Are You:</p> <p>Pregnant.....<input type="radio"/> Yes <input type="radio"/> No</p> <p>Nursing.....<input type="radio"/> Yes <input type="radio"/> No</p> <p>Taking Birth Control Pills<input type="radio"/> Yes <input type="radio"/> No</p> |
|---|--|

Have you been diagnosed with any of the following?

- | | | |
|---|---|--|
| AIDS..... <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | Pacemaker <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Epilepsy <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis, Rheumatism..... <input type="radio"/> Yes <input type="radio"/> No | Fainting or Dizziness <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatment <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valves <input type="radio"/> Yes <input type="radio"/> No | Glaucoma..... <input type="radio"/> Yes <input type="radio"/> No | Respiratory Disease <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joints <input type="radio"/> Yes <input type="radio"/> No | Headaches <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever..... <input type="radio"/> Yes <input type="radio"/> No |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur..... <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No |
| Back Problems..... <input type="radio"/> Yes <input type="radio"/> No | Heart Problems..... <input type="radio"/> Yes <input type="radio"/> No | Shortness of Breath..... <input type="radio"/> Yes <input type="radio"/> No |
| Bleeding Abnormally, <input type="radio"/> Yes <input type="radio"/> No
<i>with extractions or surgery</i> | Hepatitis-Type <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Herpes..... <input type="radio"/> Yes <input type="radio"/> No | Skin Rash <input type="radio"/> Yes <input type="radio"/> No |
| Cancer <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Chemical Dependency..... <input type="radio"/> Yes <input type="radio"/> No | HIV Positive..... <input type="radio"/> Yes <input type="radio"/> No | Swelling of Feet/Ankles..... <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy..... <input type="radio"/> Yes <input type="radio"/> No | Jaundice..... <input type="radio"/> Yes <input type="radio"/> No | Swollen Neck Glands <input type="radio"/> Yes <input type="radio"/> No |
| Chronic Fatigue Syndrome..... <input type="radio"/> Yes <input type="radio"/> No | Jaw Pain..... <input type="radio"/> Yes <input type="radio"/> No | Thyroid Problems..... <input type="radio"/> Yes <input type="radio"/> No |
| Circulatory Problems <input type="radio"/> Yes <input type="radio"/> No | Kidney Disease..... <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis..... <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Lesions <input type="radio"/> Yes <input type="radio"/> No | Latex Sensitivity <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Cortisone Treatments <input type="radio"/> Yes <input type="radio"/> No | Liver Disease..... <input type="radio"/> Yes <input type="radio"/> No | Tumor or Growth on Head/Neck... <input type="radio"/> Yes <input type="radio"/> No |
| Cough, Persistent or Bloody..... <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure..... <input type="radio"/> Yes <input type="radio"/> No | Ulcer <input type="radio"/> Yes <input type="radio"/> No |
| Diabetes <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse..... <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease..... <input type="radio"/> Yes <input type="radio"/> No |
| | Nervous System Problems..... <input type="radio"/> Yes <input type="radio"/> No | |