ENDODONTICS

NAME	REFERRING DOCTOR:
ADDRESS	EMERGENCY CONTACT:
CITY STATE ZIP	PHONE:
HOME PHONE	ADDRESS:
WORK PHONE	**INSURANCE INFORMATION**
SOCIAL SECURITY NO.	COMPANY
BIRTH DATE	ADDRESS
OCCUPATION	
EMPLOYER	PHONE GROUP#
BUSINESS ADDRESS	RELATION OF EMPLOYEE: SELF( ) SPOUSE ( ) CHILD ( )
SPOUSE/PARENT	**RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS**
NAME	I authorize the release of any dental information necessary in order to process insurance claims, and I authorize payments of dental benefits to Charles R. Glosson, DMD, Pedro F. Amador, DMD and /or Derek A. Slosser, DMD for professional services rendered.
EMPLOYER PHONE	I agree that I am responsible for all dental fees and that my insurance is filed as a courtesy to me. I am responsible for any outstanding insurance balance over 60 days of date of service.
BUSINESS ADDRESS	
CITY STATE ZIP	
SOCIAL SECURITY NO. D/O/B	

HEALTH HISTORY

	YES	NO		YES	NO		YES	NO
AIDS or ARC			Dizziness/Fainting			Kidney Disease		
Allergies/Drugs/Latex			Drug/Alcohol Addiction			Liver Disease		
Artificial Joint/Valve			Frequent Swollen Ankles			Low Blood Pressure		
Asthma			Gastrointestinal/Ulcers			Lung Disease		
Bleeding Tendency			HIV Positive			Nervous Problems		
Bronchitis			Heart or Chest Pain			Pregnant/Nursing		
Cancer			Heart Murmur/MVP			Radiation Therapy		
Chemotherapy			Heart Trouble/Pacemaker			Recent Illness		
Convulsions/Seizures			Hepatitis			Rheumatic Fever		
Cortisone or Steroids			Herpes			Tuberculosis		
Diabetes/Hypoglycemia			High Blood Pressure			Thyroid Problems		
ARE YOU UNDER THE CARE OF A PHYSICIAN?						Dr.?		
HAVE YOU EVER BEEN HOSPITALIZED FOR A SERIOUS ILLNESS?								
HAVE YOU EVER RESPONDED UNFAVORABLY TO DENTAL CARE?								
IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT?								
HAVE YOU EVER TAKEN THE DIET PILLS PHEN-FEN OR REDUX?								
HAVE YOU EVER TAKEN MEDICATION FOR OSTEOPOROSIS OR HIGH BLOOD CALCIUM?								

HAVE YOU HAD AN UNFAVORABLE ALLERGIC DRUG REACTION TO: Circle Please

None	Codeine	Erythromycin	Cleocin
Penicillin	Keflex	Anesthetics	Other?

I AM PRESENTLY TAKING: Circle Please

No Drugs	Pain Medication	Birth Control	Blood Thinner/ Aspirin
Antibiotic	Herbal Medications	Cortisone/Steroids	Blood Pressure Medicine

Other:

PATIENT SIGNATURE: **DATE:**