Central Florida Endodontics

PATIENT INFORMATION

Name:

Gender: DOB:

Street:

City: State: Zip:

Cell Phone:

Work Phone:

Employer:

PARENT OF MINOR/EMERGENCY CONTACT

Name:

Gender: DOB:

Relationship to Patient:

Street:

City: State: Zip:

Cell Phone: Work Phone:

Employer:

Referring Dentist:

INSURANCE INFORMATION

Insurance Company:

Insurance Company Phone #:

Name of Insured:

Insured ID/SS#:

Insured DOB:

Acquired through: ☐ Employer ☐ Self-purchased

Group Name:

Group #:

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

I authorize the release of any dental information necessary in order to process insurance claims, and I authorize payments of dental benefits to Central Florida Endodontics for professional services rendered.

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.

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			Pacemaker		
Cancer			Heart Murmur/MVP			Pregnant/Nursing		
Chemotherapy			Heart Trouble			Radiation Therapy		
Convulsions/Seizures			Hepatitis			Rheumatic Fever		
Cortisone or Steroids			Herpes			Tuberculosis		
Diabetes/Hypoglycemia			High Blood Pressure			Thyroid Problems		

Yes No Are you under the care of a physician? Who?

Yes No Do you need to pre-medicate 1 hour before dental work? Why?

Yes No Have you ever been hospitalized for a serious illness? What?

Yes No Have you ever responded unfavorably to dental care? How?

Yes No Have you ever taken medication for Osteoporosis or High Blood Calcium?

Yes No Is there anything else we should know about?

HAVE YOU HAD AN UNFAVORABLE OR ALLERGIC DRUG REACTION TO:

None	Codeine	Erythromycin	Cleocin
Penicillin	Keflex	Anesthetics	Other?

I AM PRESENTLY TAKING:

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

Patient Signature: **Date:**