Auburn Valley Endodontics

PATIENT INFORMATION

Please Print

Name _____
(Mr. , Mrs. , Miss) First MI Last

Home Address _____ Apt# _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Employer _____

Date of Birth _____

Emergency Contact - Name _____ Phone _____

(if patient is a minor) Name of Parent _____

INSURANCE INFORMATION

Primary Insurance _____ Group No. _____

Subscriber _____ I.D. No. _____

Relationship to Patient _____ Date of Birth _____

Secondary Insurance _____ Group No. _____

Subscriber _____ I.D. No. _____

Relationship to Patient _____ Date of Birth _____

HEALTH HISTORY	YES	NO
Have you been treated by a physician during the last two years?	☐	☐
If yes, explain _____		
Are you taking any medications at present?	☐	☐
If yes, please list _____		
Are you allergic or sensitive to penicillin, Novocaine, Codeine, Latex or any	☐	☐
other medications? Please list _____		
Have you ever had unfavorable reaction after dental treatment?	☐	☐
Female patients, are you pregnant? Which month? _____	☐	☐
Do you require antibiotic pre-medication before dental treatment?	☐	☐

Have you ever had any of the following illnesses? (please circle)

Rheumatic Fever	Nervous disorders	Fainting
Kidney disease	High blood pressure	Hepatitis
Epilepsy	Heart valve replacement	Tumors
Stroke	Joint replacement	Tuberculosis
Asthma	Heart pacemaker	Venereal disease
Diabetes	HIV/AIDS	
Heart trouble	Excessive Bleeding	

Any other information about your health condition that should be known?

_____

The above information is accurate and complete to the best of my knowledge.

Patient/Parent's Signature _____ Date _____