MARTIN ENDODONTICS
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PATIENT INFORMATION

Date_____

Primary Phone # Home/Business/Cell_____ Secondary Phone #_____

Name_____Soc. Sec.#_____

Address_____City_____

State_____ Zip_____ Drivers License#_____

Patient Email Address:_____

Sex: M____F____ Birthdate: _____ Marital Status: M____S____D____W____DP____

Employer_____Occupation_____

Business Address_____City_____Zip_____Phone #_____

Spouse/Domestic Partner/Parents Name_____Phone #_____

Whom may we thank for referring you?_____

Person to contact in case of emergency_____Phone #_____

RESPONSIBLE PARTY

Who is legally responsible, if other than patient?_____Relationship_____
Address_____City_____State_____Zip_____
Drivers License#_____Birthdate_____Phone #_____

DENTAL INSURANCE INFORMATION

Name of insured_____Relationship_____

Birthdate_____Soc. Sec.#_____Date Employed_____

Employer_____Business Phone_____

Business Address_____City_____State_____Zip_____

Insurance Company_____Group #_____

Address_____City_____State_____Zip_____

DENTAL HISTORY

Reason for today's visit_____
Are you having pain or discomfort at this time? Y___N___ Have you ever had root canal therapy (endodontic treatment)? Y___N__
General Dentist_____Phone_____

Review Date: _____	Int. _____
Review Date: _____	Int. _____
Review Date: _____	Int. _____
OFFICE USE ONLY	

MEDICAL HISTORY

Primary Physician_____ Tel:_____ Date of last exam_____

Have you ever had any serious illnesses/operations?_____ Describe_____

Have you been hospitalized in the last 5 years?_____ Describe_____

(Women)Are you pregnant?_____ Due Date_____ Nursing?_____ Are you taking oral contraceptives?_____

Check **Yes** or **No** of the following which you had or have at the present

DENTAL
Y N
☐☐Blisters
☐☐Chronic pain
☐☐Clenching
☐☐TMJ
☐☐Gum Surgery
☐☐Orthodontics

NEUROMUSC
☐☐Arthritis
☐☐Back Injury
☐☐Epilepsy
☐☐Seizures
☐☐Fainting Spells
☐☐Numbness

CARDIOVASCULAR
Y N
☐☐Angina/Chest pain
☐☐Artificial Valves
☐☐Cardiac Surgery
☐☐Circulatory Problems
☐☐Difficulty breathing
☐☐Endocarditis
☐☐Heart Attack
☐☐Heart Murmur
☐☐Irregular Heart Beat
☐☐Mitral Valve Prolapse
☐☐Pacemaker
☐☐Rheumatic fever
☐☐Scarlet fever
☐☐Stroke
☐☐High Blood Pressure

HEAD/NECK
Y N
☐☐Chronic Sinusitis
☐☐Problems swallowing
☐☐Eye Disease
☐☐Trauma
☐☐Thyroid Disease

OTHER
☐☐Hepatitis A B C
☐☐Liver Disease
☐☐Organ Transplant
☐☐Renal Dialysis

RESPIRATORY
☐☐Asthma/Emphysema
☐☐Pneumonia
☐☐Tuberculosis

HEMA/IMMUNE
Y N
☐☐Adrenal
☐☐AIDS/HIV
☐☐Anemia
☐☐Transfusions
☐☐Bruising
☐☐Cancer
☐☐Chemotherapy
☐☐Radiation
☐☐Psychiatric Care
☐☐Diabetes
☐☐Venereal Disease

SUPPLEMENTAL
☐☐Bisphosphonates

If you have a current medical problem or another condition not listed here, describe_____

_____

Have you ever been advised to take an antibiotic premedication before your appointment?_____

Are you sensitive or allergic to any medication such as:

Y N ☐☐Penicillin Y N ☐☐Erythromycin Y N ☐☐Clindamycin Y N ☐☐Codeine Y N ☐☐Aspirin Y N ☐☐Latex

☐☐Anesthetics **Other**_____

Do you currently use any recreational drugs? ☐**Y**☐**N**

List of medications you are currently taking:

_____

_____

_____

Purpose of medications:

_____

_____

_____

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge. If I ever have a change in my health or medications, I will inform this office at the next appointment without fail. I authorize and request my insurance company to pay directly to the dentist or the dental group insurance benefits otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all submissions I understand payment is due in full at the time of treatment. I understand a minimum $90.00 for a broken appointment without 24 hours notice or legitimate cause will be my responsibility.

Signature of patient/parent_____ **Date**_____