THE ENDODONTIC GROUP, INC.

Dallas and Frisco

www.endogroupinc.com

Please Print

______ ________________________ _____ ____
Dr/Mr/Mrs/Ms First Name MI Last Name

(Nickname) _______________ Male___ Female___ Date of Birth_______________ Social Security # _________________

Home Address ____ Apt # ______City______________ State _________

Zip Code _____________ Telephone # _____________________________ Cell # _________________________

Email address_________________________________

How would you like to be contacted?

(Check one please) Home Telephone _____ Work Telephone _____ Text _____ Email _____

Employed by __________________________Occupation ___________________Work Telephone_________________

Business Address _______________________________________ ____________________ _______________
Street City and State Zip Code

In case of emergency call ____ Telephone ________________

Relationship ____________________________

Responsible Party's Information or if Patient is a dependent:

Name ____ Relationship ________________________________

Telephone _________________ Date of Birth _________________ Social Security # ______________________

Employed by: ____ Work Telephone ________________________

Who referred you to us? ________________________**General Dentist** ___________________**Phone #** ___________

Do you usually use nitrous oxide (laughing gas) during treatment? Yes ____ No _____

Do you require another type of sedation during dental treatment? Yes ____ No _____

Allergy to Latex Yes ☐ No ☐

Allergy to Local Anesthetics Yes ☐ No ☐

Allergy to Penicillin Yes ☐ No ☐

Allergies to Other Medications (list all please)

____

Please list all medications you are currently taking below:

____

____

Are you pregnant or nursing? ________ Trimester ___________ Due Date _____________

OB/GYN name ____________________________ Phone number _____________________________________

Health History

Age ____ Last Medical Exam___________ Height ________ Weight _______ Are you in good health? Yes ___ No ___

Are you currently under the care of a Physician? Yes____ No ____ Treatment for: ___________________________

Name of your Medical Doctor ______________________________________ Phone number ________________________

Preferred Pharmacy and telephone number ____

Have You Ever Been Diagnosed or Treated **For the Following?**

A Positive Test for HIV	Yes ☐	No ☐
AIDS	Yes ☐	No ☐
Hepatitis A __ B__ C ___	Yes ☐	No ☐
Tuberculosis Active ____ Inactive ___	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐
Heart Condition	Yes ☐	No ☐
Pacemaker	Yes ☐	No ☐
Damaged / Artificial Heart Valves	Yes ☐	No ☐
Heart Murmur or Rheumatic Heart Disease	Yes ☐	No ☐
Abnormal Blood Pressure	Yes ☐	No ☐
Artificial Joint	Yes ☐	No ☐
Hemophilia or Blood Thinners / Aspirin	Yes ☐	No ☐
Ulcers	Yes ☐	No ☐
Addiction (drugs, alcohol etc.)	Yes ☐	No ☐
Thyroid Disease	Yes ☐	No ☐
Cancer / Other Autoimmune Disease	Yes ☐	No ☐
Arthritis or Gout	Yes ☐	No ☐
Stroke or Neurological Disease	Yes ☐	No ☐
Epilepsy or Seizures	Yes ☐	No ☐
Pulmonary / Lung Disease	Yes ☐	No ☐
Asthma /Allergies/Sinus	Yes ☐	No ☐
Are you currently taking or have you previously taken: Bisphosphonate medications such as Fosamax, Actonel, Zometa or Boniva?	Yes ☐	No ☐

I authorize release of any information relating to an insurance claim. I understand that I am responsible for all costs of dental treatment.

Patient's Signature ____ **Date** ____________________