Medical History

Please take a few minutes to answer the following questions so we can better assist you with your health care needs.

Referring Dentist _____ Medical Doctor _____

Are you currently under medical treatment? If so, please describe _____

_____

Are you currently taking any medications? If so, please list _____

_____

Have you had any allergic reactions to the following? If yes, please list what kind and type of reaction, otherwise check No box.

Yes	No		
❑	❑	Local anesthetic (eg., novocaine)	_____
❑	❑	Penicillin	_____
❑	❑	Other antibiotics	_____
❑	❑	Sulfa drugs	_____
❑	❑	Barbiturates (eg., phenobarbital)	_____
❑	❑	Sedatives (eg., Valium)	_____
❑	❑	Iodine	_____
❑	❑	Aspirin	_____
❑	❑	Latex	_____
❑	❑	Metals	_____
❑	❑	Other	_____

Please check the box if you have ever had the following:

Yes	No		Yes	No	
❑	❑	Stroke	❑	❑	Blood disease
❑	❑	High blood pressure	❑	❑	Pacemaker
❑	❑	Diabetes	❑	❑	Cancer
❑	❑	Epilepsy	❑	❑	Kidney disease
❑	❑	Heart murmur	❑	❑	Chemical dependency
❑	❑	Heart problems	❑	❑	Rheumatic fever
❑	❑	Hepatitis	❑	❑	Joint replacement
❑	❑	Asthma	❑	❑	Thyroid
❑	❑	HIV/Aids	❑	❑	Mitral valve prolapse
❑	❑	Back problems	❑	❑	Ulcers
❑	❑	Low blood pressure	❑	❑	Do you need to be premedicated?
❑	❑	Glaucoma	❑	❑	Do you take oral contraceptives?
			❑	❑	Are you pregnant?

I certify that I have read and understand the above information and the questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care. To third party payers and/or health practitioners, I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier **may pay less** than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient or parent/guardian of minor

X _____

Doctor's Signature

Welcome to  ***St. Croix Endodontics, PA***

Patient Information Date _____

Name _____ Sex: M F

Address _____ Home Phone _____

City _____ State _____ Zip _____

Soc. Sec. # _____ Birthdate _____

Cell Phone _____ Minor Married Single Divorced Widowed

Employer _____ Work Phone _____

Spouse's Name _____ Birthdate _____

Emergency Contact _____ Phone _____

Person Responsible for Account _____

If student, name of college/school _____

Primary Insurance

Policy Holder's Name _____ Relationship _____

Birthdate _____ Soc. Sec. # _____

Employer _____ Insurance Company _____

Subscriber I.D. _____ Group # _____

Address _____ City _____ State _____ Zip _____

Secondary Insurance

Policy Holder's Name _____ Relationship _____

Birthdate _____ Soc. Sec. # _____

Employer _____ Insurance Company _____

Subscriber I.D. _____ Group # _____

Address _____ City _____ State _____ Zip _____

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