STONESTOWN ENDODONTICS

The following patient information will be used for our records only

Last Name:	**First Name:**	**SSN:**
		Birthday: / /
Address: **Street** **City** **Zip Code**		**Gender:** ☐ Male ☐ Female
Home #:	**Cell #:**	**Email:**

Whom may we thank for referring you (if other than your dentist)? _____

Name of Dentist: _____ Dentist's Phone #: _____

Emergency Contact Name: _____ Emergency Contact's Phone #: _____

Relationship to Patient: _____

Employer: _____ Employer's Phone #: _____

Family Physician: _____ Physician's Phone #: _____

MEDICAL HISTORY

1. Are you allergic to any of the following?

Latex ☐ Yes / ☐ No	Other, not listed (please specify):	Doctor's Use Only ____/____/____
Penicillin ☐ Yes / ☐ No		
Sulfa Drugs ☐ Yes / ☐ No		

2. Do you have any reactions to local anesthetics?
   ☐ Yes / ☐ No (please specify) _____

3. Have you been hospitalized within the past two years?
   ☐ Yes / ☐ No (please specify) _____

4. Are you currently under the care of a physician for a specific medical condition?
   ☐ Yes / ☐ No (please specify) _____

5. Are you currently taking any medications or drugs?
   ☐ Yes / ☐ No (please specify) _____

6. Have you ever taken bisphosphonate medications (i.e. for osteoporosis)?
   ☐ Yes / ☐ No (please specify) _____

7. Have you ever had any of the following?

High blood pressure ☐ Yes / ☐ No	Respiratory problems ☐ Yes / ☐ No	Other, not listed (please specify):
Heart disease ☐ Yes / ☐ No	Hepatitis / Liver disease ☐ Yes / ☐ No	
Heart murmur ☐ Yes / ☐ No	Kidney disease ☐ Yes / ☐ No	
Rheumatic fever ☐ Yes / ☐ No	Tuberculosis ☐ Yes / ☐ No	
Joint prosthesis ☐ Yes / ☐ No	Sinus trouble ☐ Yes / ☐ No	
Diabetes ☐ Yes / ☐ No	HIV / AIDS ☐ Yes / ☐ No	
TMJ problems ☐ Yes / ☐ No	Cancer ☐ Yes / ☐ No	

8. Are you pregnant? ☐ Yes / ☐ No 9. Are you breastfeeding? ☐ Yes / ☐ No

ALL THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE

Patient/Guardian Signature: _____ Date: _____/_____/_____

Guardian's Full Name (if patient is under 18 years of age, please print): _____