ADVANCED ENDODONTIC GROUP

Welcome!

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (Confidential)

Patient # _____ Soc. Sec. # _____ Date: _____

Name: _____ Birthdate: _____ Home Phone: _____

Address : _____ City: _____ State: _____ Zip: _____

Check Appropriate Box: Minor ☐ Single Married ☐ Divorced D Widowed D Separated

If Student, Name of School I College: _____ City: _____ State: _____

Full time ☐ Part time ☐

Patient's or Parent's Employer: _____ Work Phone: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse or Parent's Name: _____ City: _____ State: _____ Zip: _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency: _____ Phone: _____

Responsible party

Name of Person Responsible for this Account: _____ Relationship to Patient: _____

Address: _____ Home Phone: _____

Driver's License # _____ Birthdate: _____ Financial Institution: _____

Employer: _____ Work Phone: _____ SS # _____

Is this Person Currently a Patient in our Office? Yes ☐ No ☐

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash ☐ Personal Check ☐

Credit Card: VISA ☐ MasterCard ☐

I wish to discuss the office's payment policy ☐

Insurance Information

Name of insured: _____ Relationship to Patient: _____

Birthdate: _____ Social Security # _____ Date Employed: _____

Name of Employer: _____ Union or Local # _____ Work Phone: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group # _____ Policy/JD # _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit: _____

Do you ha ve any additional insurance? Yes ☐ No ☐

If yes, complete the following:

Name of insured: _____ Relationship to Patient: _____

Birthdate: _____ Social Security # _____ Date Employed: _____

Name of Employer: _____ Union or Local # _____ Work Phone: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group # _____ Policy/JD # _____

Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit: _____

Patient Medical History

Physician: _____ Office Phone: _____ Date of Last Exam: _____

	Sí	No
Are you under medical treatment now?	☐	☐
Have you ever been hospitalized for anysurgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
Are you taking any medication(s) including non-prescription medicine?	☐	☐
If yes, what medication(s) are you taking? _____		
Have you ever taken Phen-Fen/Redux?	☐	☐
Do you use tobacco?	☐	☐
Do you use controlled substances?	☐	☐
Are you wearing contact lenses?	☐	☐
Do you have or have you had any of the following?	☐	☐
Are you allergic to or have you had any reactions to the following?	☐	☐

	Sí	No
Local Anesthetics (eg. Novocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list) _____		

Women Only:

Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
	☐	☐

	Sí	No
High Blood Pressure	☐	☐
Heart Attack	☐	☐
Rheumatic Fever	☐	☐
Swollen Ankles	☐	☐
Fainting I Seizures	☐	☐
Asthma	☐	☐
Low Blood Pressure	☐	☐
Epilepsy I Convulsions	☐	☐
Leukemia	☐	☐
Diabetes	☐	☐
Kidney Diseases	☐	☐
AIDS or HN Infection	☐	☐
Thyroid Problem	☐	☐
Heart Disease	☐	☐
Cardiac Pacemaker	☐	☐
Heart Murmur	☐	☐
Angina	☐	☐
Frequently Tired	☐	☐
Anemia	☐	☐
Emphysema	☐	☐

	Sí	No
Cancer	☐	☐
Arthritis	☐	☐
Joint Replacement or Implant	☐	☐
Hepatitis I Jaundice	☐	☐
Sexually Transmitted Disease	☐	☐
Stomach Troubles I Ulcers	☐	☐
Chest Pains	☐	☐
Stroke	☐	☐
Hay Fever I Allergies	☐	☐
Tuberculosis	☐	☐
Radiation Therapy	☐	☐
Glaucoma	☐	☐
Recent Weight Loss	☐	☐
Liver Disease	☐	☐
Heart Trouble	☐	☐
Respiratory Problems	☐	☐
Mitral Valve Prolapse	☐	☐

Other _____

Patient Dental History

Physician: _____ Office Phone: _____ Date of Last Exam: _____

	Sí	No
Do your gums bleed while brushing or flossing?	☐	☐
Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
Do you feel pain to any of your teeth?	☐	☐
Do you have any sores or lumps in or near your mouth?	☐	☐
Have you had any head, neck or jaw i,yuries?	☐	☐
Have you ever experienced any of the fallowing problems in your jaw?	☐	☐
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Sí	No
Do you have frequent headaches?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you bite your lips or cheeks frequently?	☐	☐
Have you ever had any difficult extractions in the past?	☐	☐
Have you ever had any prolonged bleeding following extractions?	☐	☐
Have you had any orthodontic treatment?	☐	☐
Do you wear dentures or partials?	☐	☐
If yes, date of placement		
Have you ever received oral hygiene instruction regarding the care of your teeth and gums?	☐	☐

Doctor's Comments _____

Signature of patient (or parent if minor) _____ Date _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. 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 payors and/o health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. 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.