SAN JOSE ENDODONTICS

Name: _____
Last (Mr. Mrs. Ms.) First Middle Initial

Birth Date _____ Social Security # _____

Home Address _____Home Phone_____

_____Other Phone _____
City State Zip

Referring Dentist _____Medical Physician/Phone_____

Emergency Contact _____ Phone _____

MEDICAL HISTORY

How would you rate your current health? (circle one) Good Fair Poor

Have you been hospitalized or had any recent prolonged illness or disease? _____

Are you now using any prescribed medications? If so, please list: _____

_____

Are you sensitive or allergic to any dental anesthetic? _____

Are you sensitive or allergic to any medications? _____

Have you taken bisphosphonates such as Fosamax in the past? _____

(Women) Are you pregnant or nursing? _____

Do you have or have you had any of the following? **Please circle Yes or No**

Yes No **Alcoholism**
Yes No **Allergies to latex**
Yes No **Allergies to metals**
Yes No **Angina**
Yes No **Asthma**
Yes No **Bleeding problems**
Yes No **Cancer**
Yes No **Diabetes**
Yes No **Dizziness or Fainting**
Yes No **Epilepsy/Convulsions**
Yes No **Glaucoma**
Yes No **Heart attack**
Yes No **Heart disease**
Yes No **Heart murmur**
Yes No **Heart valve replacement**
Yes No **Hepatitis: A, B or C**
Yes No **High Blood Pressure**
Yes No **H.I.V.**
Yes No **Joint replacement**
Yes No **Kidney disease**
Yes No **Liver disease**
Yes No **Problems healing**
Yes No **Psychiatric care**
Yes No **Recreational drugs**
Yes No **Sinus trouble**
Yes No **Stroke**
Yes No **Ulcers**
Yes No **Venereal disease**

Dr's. Initials: _____

Other health condition(s) which we should be aware of? _____

_____

Do you allow our office to e-mail your x-rays to other dental offices? YES NO _____ Patient Initials
I am aware that this office is HIPAA compliant. _____ Patient Initials

Signature _____ Date _____
(Patient, Parent or Guardian)

I confirm as true the above medical history information and give consent to agreed upon dental services and use of appropriate methods on my behalf.
IF YOU DO NOT INTEND TO PAY CASH IN FULL TODAY, PLEASE CONTINUE ON REVERSE SIDE.

For doctors use only. Medical updates: Date/Init _____ Date/Init_____ Date/Init_____

PLEASE PROVIDE US WITH THE FOLLOWING DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Employee Name _____	Employee Name _____
Birth Date _____	Birth Date _____
SS# or ID# _____	SS# or ID# _____
Employer _____	Employer _____
Dental Ins. Co. _____	Dental Ins. Co. _____

I hereby authorize my insurance benefits to be paid directly to San Jose Endodontics. I am financially responsible for services not covered or paid for by my insurance company for any reason. I also authorize this office to release any information required about my dental condition/treatment needed to determine benefits for as long as it takes to have the claim settled.

Signature _____ Date _____
(Patient, Parent or Guardian)