JENKINTOWN
ENDODONTICS LLC

PLEASE PRINT DATE _____

MR. MRS.
MS. DR. _____

Street _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Cell Phone _____ E-mail _____

SS# _____ BIRTH DATE _____

Occupation _____ Referred by Dr. _____

How long have you been his/her patient? _____

Are you a former patient of ours? _____

HEALTH INFORMATION

1. Have you ever had:	CIRCLE	
Heart Condition	YES	NO
High Blood Pressure	YES	NO
Thyroid Condition	YES	NO
Hepatitis	YES	NO
Gastro Intestinal Problems	YES	NO
Kidney Disease	YES	NO
Allergies	YES	NO
Asthma	YES	NO
Sinus Pain	YES	NO
Diabetes	YES	NO
Abnormal Bleeding	YES	NO
Epilepsy	YES	NO
Prosthetic Joint Replacement	YES	NO
HIV/AIDS	YES	NO
Have you ever taken medications for osteoporosis?	YES	NO
2. (Women) Are you pregnant?	YES	NO
3. Are you taking any medication or supplements?	YES	NO

Please list _____

_____

_____

4. Have you ever had an unusual reaction to:	CIRCLE	
Latex products	YES	NO
Local anesthetic	YES	NO
Penicillin	YES	NO
Any other drug	YES	NO

5. Are you being treated by a physician? YES NO
For what condition(s) _____

_____

Physician's name: _____

6. Is there any other information about your health which we should know? _____

_____

_____

_____

_____

Dental Insurance: _____

Subscriber: _____ D.O.B.: _____

Employer: _____

Your ID Number: _____

Group Number: _____

Payment for service is due at the time of treatment.
We will complete your insurance form for you so that you may receive reimbursement according to the terms of your policy.

When your root canal is completed, your tooth will need a surface restoration. Your dentist will render this service which is equally important for the preservation of your tooth.

I hereby certify that the information given by me is correct to the best of my knowledge, and I have reviewed the office privacy policy (H.I.P.A.A.) information.

Your signature _____