JENKINTOWN
ENDODONTICS LLC

PLEASE PRINT DATE _____

Mr. Mrs.
Ms. Dr. _____

Street _____

City _____ State_____ Zip _____

Home Phone _____ Cell Phone _____

E-mail _____ Birth Date _____

Occupation _____ Referred by Dr. _____

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
Abnormal Bleeding	YES	NO
Epilepsy	YES	NO
Prosthetic Join Replacement	YES	NO
HIV / AIDS	YES	NO
Have you ever taken medications for osteoporosis?	YES	NO
2. Hospitalizations?	YES	NO
3. (Woman) Are you Pregnant?	YES	NO
4. Are you taking medication(s) or supplements?	YES	NO

Please List _____

_____

5. Have you ever had a reaction to:	CIRCLE	
Latex products	YES	NO
Local anesthetic	YES	NO
Penicilllin	YES	NO
Any other drug	YES	NO

Please List _____

6. Are you being treated by a physician? YES NO

For what condition(s)? _____

_____

Physician's name: _____

Number: _____

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

_____

_____

Dental Insurance: _____

Subscriber: _____ DOB: _____

Your ID Number: _____

Group Number: _____

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

I hereby certify that the information given to 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 _____