SOUTH BAY ENDODONTICS
Practice Limited to Endodontics

HEALTH HISTORY & REGISTRATION

PATIENT'S NAME: Last_____ First _____ Middle_____

ADDRESS:_____ CITY, STATE, ZIP_____

HOME PHONE:_____ WORK PHONE:_____ CELL / PAGER_____

SEX: M F BIRTH DATE ____/____/____ AGE____ SOC. SEC.# _____

MARITIAL STATUS: _____ DRIVER'S LICENSE #_____ EMAIL:_____

EMPLOYER_____OCCUPATION_____# OF YEARS EMPLOYED____

INSURANCE SUBSCRIBER (IF SOMEONE OTHER THAN THE PATIENT) RELATION TO PATIENT_____

NAME: Last_____ First _____ Middle_____

ADDRESS:_____ CITY, STATE, ZIP_____

HOME PHONE:_____ WORK PHONE:_____ CELL / PAGER_____

BIRTH DATE ____/____/____ SOC. SEC.# _____ DRIVER'S LICENSE #_____

RESPONSIBLE PARTY IS ALSO ☐ PRIMARY INSURANCE POLICY HOLDER ☐ SECONDARY INSURANCE POLICY HOLDER

PRIMARY INSURANCE INFORMATION

NAME OF INSURED: _____

EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

INSURANCE COMPANY: _____

INS. COMPANY ADDRESS: _____

SECONDARY INSURANCE INFORMATION

NAME OF INSURED: _____

EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

INSURANCE COMPANY: _____

INS. COMPANY ADDRESS: _____

It is important that we know about your Medical history. These facts have a direct bearing on your dental health. This information is strictly confidential and will not be released to anyone without your permission. Thank you for answering the following questions.

	YES	NO	N/A	
Are you under a physician's care?	☐	☐	☐	_____
Have you ever been hospitalized or had a major operation?	☐	☐	☐	_____
Are you taking medications, pills, or drugs?	☐	☐	☐	_____
Are you taking alendronate(fosamax) or risedronate(actonal) ?	☐	☐	☐	_____
For women: are you pregnant?	☐	☐	☐	_____
Do you use cigars/cigarettes, pipe, or chewing tobacco?	☐	☐	☐	_____
Do you use controlled substances?	☐	☐	☐	_____

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Metal ☐ Local Anesthetics ☐ Other _____

Do you have, or had any of the following?

	YES	NO		YES	NO		YES	NO
AIDS/HIV Positive	☐	☐	Heart Disease/Attack	☐	☐	Bruise Easily	☐	☐
Angina Pectoris	☐	☐	Hepatitis A (infectious)	☐	☐	Emphysema	☐	☐
High Blood Pressure	☐	☐	Hepatitis B (serum)	☐	☐	Tuberculosis	☐	☐
Heart Murmur	☐	☐	Hepatitis C	☐	☐	Asthma	☐	☐
Rheumatic Fever	☐	☐	Liver Disease	☐	☐	Hay Fever	☐	☐
Congenital Heart Lesions	☐	☐	Blood Transfusion	☐	☐	Sinus Troubles	☐	☐
Mitral Valve Prolapse	☐	☐	Drug Addiction	☐	☐	Allergies or Hives	☐	☐
Artificial Heart Valve	☐	☐	Hemophilia (Bleeding Problem)	☐	☐	Diabetes	☐	☐
Heart Pacemaker	☐	☐	Fever Blisters	☐	☐	Thyroid Disease	☐	☐
Heart Surgery	☐	☐	Epilepsy or Seizures	☐	☐	Radiation Therapy	☐	☐
Artificial Joints (Hip, Knee)	☐	☐	Nervousness	☐	☐	Arthritis	☐	☐
Anemia	☐	☐	Psychiatric treatment	☐	☐	Cortisone Medicine	☐	☐
Stroke	☐	☐	Glaucoma	☐	☐	Pain in Jaw Joints	☐	☐
Kidney Trouble	☐	☐	Chemotherapy	☐	☐	Alcoholism	☐	☐
Ulcers	☐	☐	Venereal Disease	☐	☐	Cosmetic Surgery	☐	☐

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health.

Signature of Patient, Parent, or Guardian_____ Date:_____ Dentist Signature_____