PATIENT INFORMATION

Date: _____

Name: _____Home Phone: _____ Cell Phone: _____

Email Address: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Date of birth: _____ Sex: _____ SSN: _____

Employer: _____ Work phone: _____

Employer Street Address: _____

City: _____ State: _____ Zip: _____

REFERRAL INFORMATION

Referred by: _____ Family Dentist_____

Physician_____ Last Seen / Reason_____

INSURANCE INFORMATION

Do you have dental insurance? [ ] Yes [ ] No

Today's Date __ /__/____ Insurance Subscriber Birthdate__ /__/____

Insurance Subscriber Name: First _____ Middle_____ Last_____

Subscriber Relationship to Patient: ___Self ___Husband ___Wife ___Mother ___Father

Subscriber Social Security Number _____-_____-_____

Insurance Company Name _____

Group Plan Name _____

Subscriber ID _____

Insurance Company Address _____

City_____ State_____ Zip _____

Insurance Company Telephone Number _____

AUTHORIZATION TO PAY BENEFITS:

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTAL OFFICE OF EAST COAST ENDODONTICS FOR SERVICES RENDERED. I UNDERSTAND I AM RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE.

X_____

Signed (Patient or Parents of Minor Child)

Your signature will be maintained as 'signature on file' so that you do not have to sign insurance forms after each visit.

MEDICAL HISTORY

Place a check in the YES or NO column	***YES***	***NO***
1. Are you allergic to any medications? If YES, please list: _____	____	____
2. Are you allergic to LATEX?	____	____
3. Have you had any serious illness, operation, or hospitalization in the past?	____	____
4. Has there been a change in your health in the last 2 years?	____	____
5. Are you a "bleeder" or have you had excessive bleeding flowing dental treatment?	____	____
6. Are you presently under the care of a physician?	____	____
7. Do you smoke or use tobacco products? How much? _____ How long? _____	____	____
8. Do you drink alcoholic beverages?	____	____

HAVE YOU HAD ANY OF THE FOLLOWING*:*

	YES	*NO*		*YES*	*NO*
High Blood Pressure	____	____	Stroke	____	____
Heart Murmurs	____	____	Blood Disorders	____	____
Prolapsed Mitral Valve	____	____	Joint Implants	____	____
Rheumatic Fever	____	____	Nervous Disorders	____	____
Heart Problems	____	____	Epilepsy / Seizures	____	____
Heart Bypass Surgery	____	____	Steroid Last 2 Years	____	____
Kidney Disease	____	____	Headaches / Migraines	____	____
Diabetes	____	____	HIV Positive	____	____
Hepatitis / Liver Disease	____	____	Aids or related Complex	____	____
Dialysis	____	____	Emphysema	____	____
Thyroid Disorders	____	____	Asthma	____	____
Bleeding Problems	____	____	Tuberculosis	____	____
Angina	____	____	Oral Surgery Complications	____	____
Heart Attack	____	____	Arthritis	____	____
Pacemaker	____	____	**Women Only:**		
Chemical Dependency Treatment	____	____	Are you currently:		
Cancer	____	____	Pregnant	____	____
Radiation / Chemo	____	____	Breastfeeding	____	____

DENTAL HISTORY
Check the following that apply to you

- ☐ Swollen or bleeding gums
- ☐ Painful gums or teeth
- ☐ Loose teeth
- ☐ Bad breath or mouth odors
- ☐ Sensitivity to hot, cold or sweets
- ☐ Increasing spaces between teeth
- ☐ Bad tastes
- ☐ Clenching or grinding of your teeth
- ☐ Other _____

Please list ANY drugs or medications that you are currently taking.

DRUG	DOSAGE / HOW OFTEN	HOW LONG
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT NAME (PRINT): _____ PATIENT SIGNATURE: _____ DATE: _____

TO BE FILLED OUT BY DOCTOR:MEDICAL HISTORY REVIEWED / UPDATED ON: _____ BY: _____