Last Name	Middle Initial	Sex	Birth Date	Social Security #
First Name		M F	/ /	- -

Home Street Address		
City	State	Zip
Home Phone ( ) -		Cell Phone ( ) -
Work Number ( ) -		Alternate Phone Number ( ) -

(Numbers listed will be used, if you would not like us to call a certain number, please notate it above)

EMERGENCY CONTACT

Name	Relationship
Phone Number ( ) -	Alternate Phone Number ( ) -

Please provide us with your dentist's name, address and phone number so that we may supply them with records of your dental treatment.

Referring Dentist		Phone ( ) -	
Address			
City	State		Zip

DENTAL INSURANCE INFORMATION

Primary Insurance Company	Employer
Subscriber Name	Subscriber Social Security # - -
Group Policy #	
Relationship To Patient ☐ Self ☐ Spouse	☐ Parent/Guardian
Secondary Insurance Company (if any)	Employer
Subscriber Name	Subscriber Social Security # - -
Group Policy #	
Relationship To Patient ☐ Self ☐ Spouse	☐ Parent/Guardian

Medical History

Please complete the following questions so we may thoroughly diagnose your condition. The information you provide is for our records and will be considered strictly confidential. In addition, it is your responsibility to update this medical history when any changes occur.

Name of Physician	Phone ( ) -

Please Check and Name the Medications You Are Taking:

☐ No Medications ________	☐ Hormone ________
☐ Antibiotics ________	☐ Thyroid ________
☐ Pain Medicine ________	☐ Birth Control Pills ________
☐ Heart Medicine ________	☐ Insulin ________
☐ Aspirin ________	☐ Ulcer/Nexium ________
☐ Cortisone/Steroids ________	☐ Bone Related ________
☐ Blood Thinner ________	☐ Antidepressants ________
☐ Blood Pressure ________	

If you are taking any additional medications please list them below

1.	**2.**	**3.**
4.	**5.**	**6.**
7.	**8.**	**9.**

Have you ever had any **ALLERGIC** OR **ADVERSE** reactions to anesthetics, antibiotics, latex or other medications? ☐ YES ☐ NO If YES, please describe:

Please Check any Allergies you have:

☐ Penicillin	☐ Narcotics	☐ Food
☐ Antibiotics	☐ Local Anesthesia	☐ Bleach
☐ Aspirin	☐ Latex	☐ Iodine/Seafood
☐ Tylenol	☐ Valium/Tranquil.	
☐ Codeine	☐ Nitrous	

If you have any additional ALLERGIES, please list them below

Have you had, or do you presently have any of the following conditions? (Please check all that apply)

☐ **High Blood Pressure**	☐ **Hypoglycemia**	☐ **Ulcers/Digestive**	☐ **TMJ**
☐ **Low Blood Pressure**	☐ **Smoker**	☐ **Migraine/Headaches**	☐ **Heart Disease**
☐ **Respiratory/Asthma**	☐ **Shortness of Breath**	☐ **Epilepsy/Fainting**	☐ **Heart Murmur/Defect**
☐ **Rheumatic Fever**	☐ **Cancer**	☐ **Glaucoma/Visual**	☐ **Pacemaker**
☐ **Hypertension/Circula**	☐ **Radiation/Chemo**	☐ **Mental/Neural**	☐ **Heart Attack/Stroke**
☐ **Immunocomprised**	☐ **Tuberculosis**	☐ **Tumor/Neoplasm**	☐ **Irregular Heart Beat**
☐ **Anemia/Bleeding**	☐ **Fatigue**	☐ **Alcoholism/Addiction**	☐ **Prosthetic Implant**
☐ **Diabetes/Kidney**	☐ **Swelling**	☐ **Infections Diseases**	☐ **Any Transplant**
☐ **Herpes**	☐ **Overweight**	☐ **Venereal Diseases**	☐ **Joint Replacement**
☐ **Thyroid/Hormonal**	☐ **Underweight**	☐ **Psychiatric Care**	☐ **Arthritis**
☐ **Sinus Trouble**	☐ **Seizures**	☐ **STD**	☐ **Hepatitis/Jaundice/Liver**

1. Do you have any disease, condition, or problem not previously listed? ☐ Yes ☐ No
   If YES, please explain:____
   ____
2. Have there been ANY changes in your general health within the past year? ☐ Yes ☐ No
3. Are you currently under the care of a Physician for a current Problem? ☐ Yes ☐ No
   Nature of Treatment:____
4. Have you been hospitalized within the past five years? ☐ Yes ☐ No
   Reason:____
5. Have you had abnormal bleeding with previous extractions, surgery or trauma? ☐ Yes ☐ No
6. Have you ever been tested for HIV infection (AIDS)? ☐ Yes ☐ No
   Result of test: Positive Negative
7. Are you currently taking or have you taken any bisphosphonate medications, (e.g. Didronel, Aredia, Fosamax, Actonel, Zometa, Boniva, etc.) within the past Five years? ☐ Yes ☐ No
8. **Are you required to take antibiotics prior to ALL dental treatment?** ☐ Yes ☐ No

WOMEN ONLY

Are you Pregnant?	☐ Yes	☐ No	If Yes, How many months? _________
Are You Breastfeeding?	☐ Yes	☐ No	
Are you Taking Birth Control Pills?	☐ Yes	☐ No	

If you are taking birth control pills, please read the following Antibiotics may decrease the effectiveness of birth control medications. Therefore, if you are prescribed antibiotics during endodontic treatment, additional birth control methods should be used until your next menses.

ALL of the above information is true to the best of my knowledge. I understand that ALL fees are due on the date in which services are rendered. Should this matter be turned over for collection, all costs, including reasonable collection fees and court costs incurred by Desert Sun Endodontics shall be borne by the undersigned.

Signed:____Date:____________________
(Patient or Guardian)

Signed:____Date:____________________
(Treating Dentist)