

Southwest Endodontic Specialists, L.L.P. Houston, Texas 77027-7317

Last name _____ First name _____ Initial _____ Birth Date _____ Social Security Number _____ Home Phone _____
 Gender: Male Female Please check one: Minor Single Married Widowed Separated Divorced

Address _____ Apt. No. _____ City & State _____ ZIP Code _____

Patient's Employer _____ Occupation _____ Business Phone _____ Mobile Phone _____

Name of Spouse/Parent _____ Spouse/Parent Employer _____ Business Phone _____

*While we will file dental insurance claims on your behalf, you are responsible for charges not covered by your plan.
 PLEASE NOTE: This office does not participate in any PPO network or plan, including Delta Dental, effective December 26, 2007.*

Dental Insurance Company _____ Group Name and Number _____ Phone _____

Insured/Policy Holder Name _____ Insured's Social Security Number _____ Insured's Birth Date _____

Family Dentist _____ Referred by _____

Chief Dental Complaint _____

Is this your first visit to our office? Yes No If no, approximately what year was your last visit? _____

MEDICAL HISTORY

Circle the answer which applies. If you are uncertain, please mention it to the doctor.

- | | | | |
|---|-------|----|---|
| What is your estimation of your general health? _____ | Yes | No | Have you taken medications for osteoporosis, such as Fosamax, Actonel, Evista, Boniva, etc.? |
| Yes No Are you presently under a physician's care?
Physician's name: _____ | Yes | No | Have you ever had hepatitis?
If yes, when? _____ |
| Yes No Have you ever had an abnormal reaction to any medications? List: _____ | Yes | No | Have you been tested for HIV (AIDS) antibodies?
If yes, when? _____
Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative |
| Yes No Do you have any other allergies?
List: _____ | Yes | No | Have you ever been hospitalized? _____ |
| Yes No Are you sensitive to latex or rubber? | Yes | No | Have you ever had a hip or joint replacement?
If yes, when? _____ |
| Yes No Do you suffer from asthma or hay fever? | Yes | No | Have you previously had endodontic (root canal) treatment? |
| Yes No Have you ever had rheumatic fever? | Yes | No | Have you had psychiatric care? |
| Yes No Do you have heart trouble or murmur? | Yes | No | Has your physician prescribed any drugs for you to take for: gland trouble, heart trouble, epilepsy, to prevent blood clots, or for allergies? (Cortisone, ACTH?) |
| Yes No Do you have mitral valve prolapse or ballooning? | Yes | No | <i>Women:</i> Are you taking birth control medication?
If yes, antibiotics may reduce the effectiveness of birth control pills. |
| Yes No Do you have high blood pressure? | Yes | No | <i>Women:</i> Are you pregnant?
How many months? _____ |
| Yes No Do you get out of breath easily? | Yes | No | Are you taking any medications at this time? Please list <u>ALL</u> medications you are currently taking (prescription and over-the-counter). _____ |
| Yes No Have you ever had TB or other lung problems? | _____ | | |
| Yes No Do you have ulcers? | _____ | | |
| Yes No Do you have diabetes? | _____ | | |
| Yes No Have you ever had thyroid trouble? | _____ | | |
| Yes No Have you had eye surgery in the past 3 months? | _____ | | |
| Yes No Have you ever had trouble after an injection? | _____ | | |
| Yes No Are you anemic? | _____ | | |
| Yes No Do you take a blood thinner? | _____ | | |
| Yes No Have you ever had radiation treatment for tumors? | _____ | | |
| Yes No Have you ever had kidney disease? | _____ | | |
| Yes No Have you ever been treated for osteoporosis or osteopenia? | _____ | | |

Who filled out this questionnaire?
 Patient
 Other: Name: _____
 Relationship: _____

Signed _____ Date _____

Subsequent visits:
 Reviewed, Updated, & Signed _____ Date _____