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 Are you presently under a physician's care? Physician's name: ______

Yes No Have you ever had an abnormal reaction to any medications? List: ______

Yes No Do you have any other allergies? List: ______

Yes No Are you sensitive to latex or rubber?

Yes No Do you suffer from asthma or hay fever?

Yes No Have you ever had rheumatic fever?

Yes No Do you have heart trouble or murmur?

Yes No Do you have mitral valve prolapse or ballooning?

Yes No Do you have high blood pressure?

Yes No Do you get out of breath easily?

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?

Yes No Have you taken medications for osteoporosis, such as Fosamax, Actonel, Evista, Boniva, *etc.*?

Yes No Have you ever had hepatitis? If yes, when? ______

Yes No Have you been tested for HIV (AIDS) antibodies? If yes, when? ______ Results: ☐ Positive ☐ Negative

Yes No Have you ever been hospitalized? ______

Yes No Have you ever had a hip or joint replacement? If yes, when? ______

Yes No Have you previously had endodontic (root canal) treatment?

Yes No Have you had psychiatric care?

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 *Women*: Are you taking birth control medication? If yes, antibiotics may reduce the effectiveness of birth control pills.

Yes No *Women*: Are you pregnant? How many months? ______

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). ______

Who filled out this questionnaire?
☐ Patient
☐ Other: Name: ______
Relationship: ______

Signed ______ Date ______

Subsequent visits:
Reviewed, Updated, & Signed Date ______