SISKIYOU ENDODONTICS

PATIENT INFORMATION

Name: _____
Birth Date: _____ **Male** _____ **Female** _____ **Non-Binary**_____
Spouse/Other Name: _____ **Birth Date:** _____
Mailing Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Phones: Home: _____ **Work:** _____ **Ext:** _____
Mobile: _____ **Email:** _____
Employer: _____ **Phone:** _____
Referred By: _____ **General Dentist:** _____

PERSON RESPONSIBLE FOR ACCOUNT (if other than patient)

Name: _____
Relationship to Patient: _____ **Birth Date:** _____
Mailing Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Phones: Home: _____ **Work:** _____ **Ext:** _____
Mobile: _____ **Employer:** _____

Primary Insurance	Secondary Insurance
Ins. Co: _____	**Ins. Co:** _____
Group #: _____	**Group #:** _____
Phone: _____	**Phone:** _____
Employer: _____	**Employer:** _____
Employee (if other than patient)	**Employee (if other than patient)**
Name: _____	**Name:** _____
Birth Date: _____ **Soc. Sec.:**_____	**Birth Date:** _____ **Soc. Sec.:**_____
Subscriber #: _____	**Subscriber #:** _____

CONSENT FOR RELEASE OF INFORMATION

I, _____, give permission to release appointment, financial and treatment information to _____.
Relationship: Spouse ____ Parent____ Child____ Other____

Signature_____Date_____

I certify that the above information is accurate, and I agree that Siskiyou Endodontics will submit to my insurance for any necessary treatment performed. I also understand that my insurance may not pay as much as estimated and that I am responsible for any unpaid treatment.

Signature: _____ **Date:** _____

OVER

HEALTH HISTORY

Name: _____ **Birthdate** _____

Please answer the following questions:

Are you in good health? Yes No

Physician Name _____ When last seen _____

Have you ever had an unfavorable reaction following dental treatment? Yes No Explain _____

_____

Have you ever experienced excessive bleeding requiring special treatment? Yes No

Have you been required to take **ANTIBIOTIC PREMEDICATION** prior to **ALL DENTAL TREATMENT, including cleanings?** **Yes** **No** If so, please explain _____

Have you had prosthetic joint replacement Yes___No___If so, when? _____

Have you ever had radiation therapy on your head, face or jaw area? Yes No If so, when?_____

Are you or have you been on any **blood thinners?** Yes No

Please circle any of the following you have or have had:

Stroke Asthma Kidney trouble Heart trouble Tuberculosis

Diabetes Epilepsy High Blood Pressure Jaundice Mitral Valve Prolapse

Hepatitis Cancer Rheumatic Fever Nervous disorders

Have you ever been diagnosed with an immune system deficiency or compromised? Yes No

Are you currently, or have you ever taken a bisphosphonate class of medication (example: Zometa, Aredia, Fosamax, Boniva)? Yes No If so, please explain _____

Female patients: Are you pregnant? Yes No If so, how many weeks _____

Are you sensitive or allergic to Latex, Penicillin, Sulfa or any other medications? Yes No if so, please list

_____

_____

_____

Are you taking any medications now? Yes No if so, please list _____

_____

_____

_____

The above medical history is accurate to the best of my knowledge. I, the undersigned, consent to the performing of any procedure necessary to evaluate, diagnose and treat my condition. I authorize and request the administration of such drugs and/or anesthetics as may be deemed advisable by the dentist. **I have also received a copy of this office's Privacy Practices. (HIPAA)**

Signature _____ **Date** _____