Mountain View Endodontics

Patient Information

Date: ______________
Name: ____
Street Address: ____ Apt # ______________
City:____ State:______________ Zip:____________________
Home Phone: __________________________________Cell Phone: _____________________________________
Work Phone: _____________________________ E-mail: ____
Sex M F DOB:_______________________ Social Security # _________ - _________ - _______
Employer:____
Address ____________________________ City: ______________ State: ______________ Zip: ___________
Referring Dentist:____
Emergency Contact:___________________________ Phone # _____________ Relationship: ______________

NOTE: COMPLETE ONLY IF PATIENT IS A MINOR OR REQUIRES A LEGAL GUARDIAN

Relationship to patient: _______________________________
Name: ____
Street Address: ____ Apt # ________
City____ State:______________ Zip:_______________
Home Phone: __________________________________ Cell Phone: ______________________________
Work Phone: _____________________________ E-mail:_______________________________________

DENTAL INSURANCE

Name of insured: ____ Relation: _____________________
DOB: _________________ Employer:__________________________ Phone: ________________________
Insurance Co Name: ____
Co address: ____
City: __________________________________ State: _____ Zip: _________ Phone ________________
Group #: ______________________ SS #: _________ - _________ - _________ ID # ____________________

*Do you have **additional** dental insurance?*

Name of insured: ____ Relation: _____________________
DOB: _________________ Employer:__________________________ Phone ________________________
Insurance Co Name: ____
Co address: ____
City: __________________________________ State: _____ Zip: _________ Phone: ________________
Group #: ______________________ SS #: _________ - _________ - _________ ID # ____________________

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Medical History

Have you ever had any of the following diseases or medical conditions?

AIDS/HIV □Yes □No	Heart Attack □Yes □No	Recent Weight Loss □Yes □No
Asthma □Yes □No	Heart Murmur □Yes □No	Rheumatic Fever □Yes □No
Bleeding Problems □Yes □No	Heart Surgery □Yes □No	Seizures □Yes □No
Blood Disorders □Yes □No	Hepatitis □Yes □No	Sexually Transmitted Disease □Yes □No
Breathing Problems □Yes □No	Herpes □Yes □No	Sinus Problems □Yes □No
Cancer/Chemotherapy □Yes □No	High Blood Pressure □Yes □No	Substance Abuse □Yes □No
Colitis □Yes □No	Kidney Problems □Yes □ No	Steroid Therapy □Yes □No
Congenital Heart Disease □Yes □No	Joint Replacement □Yes □No	SBE (Subacute bact endocarditis) □Yes □No
Diabetes □Yes □No	Liver Disease □Yes □No	Thyroid Treatment □Yes □No
Emphysema □Yes □No	Mitral Valve Prolapse □Yes □No	Tuberculosis □Yes □No
Epilepsy □Yes □No	Pacemaker □Yes □No	Ulcers □Yes □No
Fainting □Yes □No	Radiation Treatment □Yes □No	Other? Specify:

Physician's Name: ______________________________________ Phone #___________________
Date & Reason of Last Visit: _________________________Your current physical health is? □Good □Fair □Poor

Do you have any medical condition not listed above or is there anything else we should know about your medical history? ____

Have you had any hospitalizations within the last 5 years? □Yes □No
If yes, why? ______________________________

Are you taking any Medications? □Yes □No
If yes, please list and include all over-the-counter medications:

____
____
____
____

Are you allergic to any medications? □Yes □No
If yes, which medications? ____________________________________

Are you allergic to Latex? □Yes □No
Are you allergic to bleach? □Yes □No

For women only:

1) Is there a possibility of pregnancy? □Yes □No
2) Are you nursing? □Yes □No

____ __________________________
Patient/ Guardian Printed Name Date

____ __________________________
Patient/ Guardian Signature Date