endodontic associates
OF MARLBORO & WORCESTER

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WWW.ENDO-ASSOCIATES.COM

PATIENT INFORMATION

Name: ______________________ Date: ______________ Sex: M or F
Last *First* *M.I.*

Birthdate: ______________ SSN: ______________ Please Circle: Single / Married / Divorced / Widowed

Address: ______________________________________
Street *City* *State* *Zip*

Home Phone: (_____) ____________ Work Phone: (_____) ____________ Cell: (_____) ____________

Email Address: ______________________________________

Occupation: ______________________ Employer: ______________________

Spouse's Name: ______________________ Spouse's Work Phone: ______________________

Emergency Contact: ______________ Relationship: ______________ Phone Number: ______________

Who is your General Dentist? ______________________ Whom may we thank for referring you? ______________

HEALTH HISTORY

Physician: ______________________ Date of Last Visit: ______________________

Phone Number: (_____) ______________________

Please mark "Yes" or "No" to indicate if you have ever had any of the following:

Condition		Condition		Condition	
Angina	❑ Yes ❑ No	Blood Disease	❑ Yes ❑ No	Thyroid: __________	❑ Yes ❑ No
Arteriosclerosis	❑ Yes ❑ No	Dizziness, Fainting	❑ Yes ❑ No	Arthritis / Rheumatism	❑ Yes ❑ No
Fibrillation	❑ Yes ❑ No	Epilepsy / Seizure	❑ Yes ❑ No	Joint Replacement (knee, hip, etc.)	❑ Yes ❑ No
Palpitations/Chest Pains	❑ Yes ❑ No	Headaches	❑ Yes ❑ No	Digestive Disorder	❑ Yes ❑ No
Heart Attack: Date: __________	❑ Yes ❑ No	Psychiatric Care	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No
Heart Defect	❑ Yes ❑ No	Vision / Hearing Impaired	❑ Yes ❑ No	Hepatitis, Type: __________	❑ Yes ❑ No
Heart Murmur/Leaky Valve	❑ Yes ❑ No	Asthma	❑ Yes ❑ No	Ulcer / Hyperactivity	❑ Yes ❑ No
High or Low Blood Pressure	❑ Yes ❑ No	Emphysema	❑ Yes ❑ No	Autoimmune / Immune Problem	❑ Yes ❑ No
Mitral Valve Prolapse/MVP	❑ Yes ❑ No	Shortness of Breath	❑ Yes ❑ No	Cancer: Type: __________	❑ Yes ❑ No
Pacemaker/Defibrillator	❑ Yes ❑ No	Sinus Infection	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No
Rheumatic or Scarlet Fever	❑ Yes ❑ No	HIV / AIDS	❑ Yes ❑ No	Birth Control Pills	❑ Yes ❑ No
Stroke: Date: __________	❑ Yes ❑ No	Swollen Glands - neck	❑ Yes ❑ No	Nursing? __________	❑ Yes ❑ No
Valve Replacement	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No	Pregnant Due: __________	❑ Yes ❑ No
Abnormal Bleeding	❑ Yes ❑ No	Herpes	❑ Yes ❑ No	Other: __________	❑ Yes ❑ No
Leukemia/Lymphoma	❑ Yes ❑ No	Diabetes: Type: __________	❑ Yes ❑ No		

Have you been told you need to PREMEDICATE or take antibiotics prior to a dental procedure? ❑ YES or ❑ NO
Which antibiotic did you take? ______________ **For what condition?** ______________

Please list any other medical concerns/conditions we should know about:

MEDICATIONS
List all medication you are currently taking

____
____
____
____
____
____
____
____

ALLERGIES
Check YES if you are allergic to:

Allergen	
Aspirin	❑ Yes ❑ No
Codeine/Other Narcotics	❑ Yes ❑ No
Iodine	❑ Yes ❑ No
Latex	❑ Yes ❑ No
Penicillin	❑ Yes ❑ No
Sulfa	❑ Yes ❑ No
Other Antibiotics: __________	❑ Yes ❑ No
Other: __________	❑ Yes ❑ No

SURGERY
List ALL past surgery, major and minor

____
____
____
____
____
____
____
____

I certify that I have read and understand the above. I have received a copy of Endodontics Associates of Marlboro Notice of Privacy Practices. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

______________________________ ______________________________
Signature of Patient **Date** **Reviewing Doctor** **Date**

PLEASE COMPLETE THE OTHER SIDE OF FORM IF YOU HAVE DENTAL INSURANCE*

RESPONSIBLE PARTY INFORMATION

Responsible Party: ______________________ Relationship to Patient: ______________________

Address: ____

Street *City* *State* *Zip*

Phone: (_____) ______________________ Birthdate: ____/____/____

____

Signature of Responsible Party *Date*

DENTAL INSURANCE INFORMATION

Name of Insured: ______________________ Relationship to Patient: ______________________

Insured's Birthdate: ____/____/____ SSN #: ____-____-____ Work Phone: (_____) ______________

Employer: ____

Insurance Company: ______________________ Group #: ____________ ID #: ____________

Ins. Co. Address: ____

Street *City* *State* *Zip*

Do you have additional insurance? ❑ YES or ❑ NO If yes, please complete the following:

Name of Insured: ______________________ Relationship to Patient: ______________________

Insured's Birthdate: ____/____/____ SSN #: ____-____-____ Work Phone: (_____) ______________

Employer: ____

Insurance Company: ______________________ Group #: ____________ ID #: ____________

Ins. Co. Address: ____

Street *City* *State* *Zip*

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I have insurance coverage as stated above, and assign directly to Endodontics Associates of Marlboro all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____

Responsible Party Signature **Date**