PATIENT INFORMATION

CONFIDENTIAL

NAME: ______________________________ Birthdate: ______________
First Middle Last

Address: ____
Street City State Zip

Home Tel.: ( ) ______________ Work Tel.: ( ) ______________

Cell: ( ) ______________ Email: ______________

Patient's or Parent's Employer: ______________ Occupation: ______________

Business Address: ____
Street City State Zip

Spouse or Parent's Name: ______________ Employer: ______________ Work Phone: ( ) ______________

If patient is a student, name of school/college: ______________ City: ______________ State: ______ Zip: ______

Name of General Dentist who referred you: ______________________________

In the event of an emergency, who should we contact?

Name: ______________ Relationship: ______________ Home Tel.: ______________ Work Tel.: ______________

PRIMARY DENTAL INSURANCE INFORMATION

Insurance Company: ______________ Subscriber ID: ______________

Group # ______________

Subscriber Information (if not patient):

Name: ______________ Relationship: ______________ Birthdate: ______________

Employer: ______________________________

Do you have any secondary dental insurance? ☐ **Yes** ☐ **No** **If yes, complete the following**

Name of Insured: ______________ Relationship: ______________ Birthdate: ______________

Subscriber Id: ______________ Employer: ______________

Group #: ______________ Insurance Company: ______________

Authorization, Release, & Agreement to Pay for Services Rendered

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and/or health practitioners. I understand that I may revoke or restrict the foregoing authorization by written instruction addressed to Western Mass Endodontics at 66 Dwight Road, Longmeadow, MA 01106.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

Patient Signature, (If minor, parent's signature): ______________________________ Date: ______________

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MEDICAL HEALTH HISTORY

PATIENT NAME: ____________________

Do you have a joint replacement or heart condition which requires antibiotic pre-medication 1 hour prior to EVERY dental appointment? YES ☐ NO ☐

PRIMARY CARE PHYSICIAN: ____________________ PHONE(S): ____________________

Are you allergic to or have you ever had any reactions to the following?

	YES	NO		YES	NO
PENICILLIN	☐	☐	**LATEX**	☐	☐
Local Anesthetics	☐	☐	Sedatives	☐	☐
Sulfa Drugs	☐	☐	Iodine	☐	☐
Barbiturates	☐	☐	Aspirin	☐	☐

Other Allergies ____________________

WOMEN ONLY:

	YES	NO
a) Are you pregnant or think you might be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐
d) Are you taking Bisphosphonates? (eg: Fosamax)	☐	☐

	YES	NO
Are you taking any medication(s) including non-prescription medicine?	☐	☐

If yes, what medication(s) are you taking? ____________________

	YES	NO
Do you use alcohol, tobacco, or other drugs?	☐	☐
Are you on any blood thinners? (eg:)	☐	☐

Plavix Warfarin Coumadin Aspirin
Xarelto Pradaxa Eliquis
(circle one)

Physician who prescribes: ____________________
Phone # ____________________

Do you have or have you ever had the following?

	YES	NO		YES	NO		YES	NO
Heart Attack	☐	☐	Asthma	☐	☐	Tuberculosis	☐	☐
Heart Disease	☐	☐	Emphysema	☐	☐	Sexually Transmitted Disease	☐	☐
Heart Murmur	☐	☐	Respiratory Problems	☐	☐	Liver Disease	☐	☐
Cardiac Pacemaker	☐	☐	Cancer	☐	☐	High Blood Pressure	☐	☐
Glaucoma	☐	☐	Leukemia	☐	☐	Low Blood Pressure	☐	☐
Joint Replacement or Implant	☐	☐	Radiation Treatment	☐	☐	Anemia	☐	☐
IBS	☐	☐	Stroke	☐	☐	Diabetes	☐	☐
Stomach Troubles/Ulcers	☐	☐	Fainting/Seizures	☐	☐	Thyroid Problem	☐	☐
Rheumatic Fever	☐	☐	Epilepsy/Convulsions	☐	☐	Kidney Disease	☐	☐
Angina	☐	☐	Hepatitis	☐	☐	Arthritis	☐	☐
Chest Pains	☐	☐	Jaundice	☐	☐	Hay Fever/Allergies	☐	☐
Arrhythmia	☐	☐	AIDS/HIV Infections	☐	☐	Frequently Tired	☐	☐

COMMENTS ____________________

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE X ____________________

PATIENT, PARENT, OR GUARDIAN DATE