Midwest Endodontics
4830 Knightsbridge Blvd. Suite L
Columbus, OH 43214-2300

Patient Information Form

Patient:

Name____

Address____

City________________________ State__________ Zip__________

SS#____________________ DOB____________________

Home phone__________ Cell phone__________ Work phone__________

Email address ______________________________________

Person Financially Responsible for this Account:

Name____

Address____

City ________________________ State__________ Zip__________

SS# ____________________ DOB ____________________

Employer ________________ Occupation ________________

Home phone__________ Cell phone__________ Work phone__________

Primary Dental Insurance ________________________Group #__________

Employer ____

Subscriber ____________________ SS#__________ DOB__________

Secondary Dental Insurance ________________________ Group#__________

Employer ____

Subscriber ____________________ SS#__________ DOB__________

Health History Form

Referring Dentist ____

General Dentist ____

Are you currently in treatment with an additional specialty dentist?______yes ______ no
If yes, name? ____

Are you pregnant?_________yes _____________no

List <u>all</u> the medications you are taking:

1.______________________________ **4.** ______________________________

2. ______________________________ **5.** ______________________________

3. ______________________________ **6.** ______________________________

Have you ever had an allergic reaction to the following:

___Penicillin/Amoxicillin
___Aspirin/NSAIDS
___Latex products
___Codeine/Narcotics
___Local anesthetic
Any other medications or foods ____

Check any of the following conditions that apply:

____Heart surgery
____High blood pressure
____Pacemaker
____Artificial heart valve
____Congenital heart conditions
____History of infective endocarditis
____History of stroke
____Diabetes
____Joint replacements
____Ulcers
____Recent surgery
____Seizure disorder
____ Bleeding disorder
____ Cancer
____ HIV/AIDS
____ Hepatitis B or C
____ Cognitive or memory problems
____ Asthma
____ Chronic sinus problems
____ Kidney problems
____ Recovering substance abuser
____ Tuberculosis
____Long term oral or IV bisphosphonate therapy for osteoporosis

Name and phone of your doctor ____

Any other information about your health ____

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