Alliance Endodontics

NAME:_____ ADDRESS:_____
CITY_____STATE:_____ZIP:_____
HOME #:_____CELL #:_____ Prefer: Home or cell
NICKNAME: _____ Drivers License #: _____
SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____ AGE: _____
REFERRING DENTIST: _____ GENERAL DENTIST: _____
PHARMACY NAME: _____ PHARMACY PHONE NUMBER: _____
PHARMACY ADDRESS: _____
EMERGENCY CONTACT NAME: _____ PHONE #: _____

DO YOU HAVE DENTAL INSURANCE: YES OR NO
INSURANCE COMPANY NAME:_____INSURANCE COMPANY ADDRESS: _____
SUBSCRIBERS NAME: _____ RELATIONSHIP TO SUBSCRIBER: _____
SUBSCRIBER SS #: _____ SUBSCRIBER DOB: _____
MEMBER ID #:_____ GROUP #: _____

1 . Are you allergic to Latex, Bleach, or any Medications? ..... Yes No
If yes, list allergies: _____
2 . Are you required to take antibiotics 1 hour prior to dental treatments? ..... Yes No
3 . Have you ever had a reaction to an anesthetic injection? ..... Yes No
4 . If female, are you pregnant or breast feeding? ..... Yes No
5 . Do you have any history of medicines for osteoporosis (IV injections or Oral)? ..... Yes No
6 . Are you currently taking any medications? ..... Yes No
If yes, please list: _____
_____
_____
7 . Have you had any major surgeries / hospitalizations? ..... Yes No
If yes, please list: _____
_____
_____
8 . Do you have any of the following:

- ☐ Heart Condition (CHF, Murmur, Angina, Heart Attack, Rhythm Problems)
- ☐ Heart Pacemaker
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Kidney Trouble
- ☐ Lung Disease
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Nervous System Disease (Anxiety, Depression, PTSD)
- ☐ Allergies / Sinus Trouble
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ High Blood Pressure
- ☐ Prolonged Bleeding
- ☐ Liver Disease
- ☐ Hepatitis (A B C D)
- ☐ AIDS / HIV
- ☐ Stomach / Intestinal
- ☐ Cancer
- ☐ Chemo / Radiation
- ☐ Seizures / Fainting
- ☐ Arthritis
- ☐ Artificial Implant / Joint
- ☐ TMJ
- ☐ Osteoporosis Therapy

9 . Do you have any disease, condition, or problem not listed?..... Yes No
If yes, please explain: _____

I have answered these questions to the best of my knowledge.

Signature _____ **Date** _____