PATIENT INFORMATION & HEALTH HISTORY

PERSONAL INFORMATION

Date:

Name (First, Middle, Last):

Address:

City: State: Zip:

Home Phone: Business Phone:

Cell Phone: Email:

Date of Birth: Social Security Number: - -

Gender: Marital Status: Spouse/Partner Name:

Employer: Current Position:

Employer Address: City: State:

Referring Dentist:

EMERGENCY CONTACT

Name: Phone: Relationship:

MEDICAL INFORMATION

Physician:

Current Physical Health: ☐ Good ☐ Fair ☐ Poor Height: Weight:

Are you currently under the care of a physician? ☐ Yes ☐ No *If yes, please explain.*

Have you had joint replacement procedures in the past? ☐ Yes *When?* ☐ No

Have you been instructed to "pre-medicate" prior to dental treatment? ☐ Yes ☐ No

Are you pregnant? ☐ Yes *Week #:* ☐ No N/A

Have you been under the care of a physician in the past 2 years? ☐ Yes ☐ No

Have you been hospitalized in the past 5 years? ☐ Yes ☐ No *If yes, list:*

PREVIOUS CONDITIONS

☐ Yes ☐ No Heart Attack/Stroke
☐ Yes ☐ No Heart Murmur
☐ Yes ☐ No Mitral Valve Prolapse
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Low Blood Pressure
☐ Yes ☐ No Heart Surgery/Pacemaker
☐ Yes ☐ No Congenital Heart Defect
☐ Yes ☐ No Blood Transfusion
☐ Yes ☐ No HIV+/AIDS
☐ Yes ☐ No Hepatitis A, B, or C
☐ Yes ☐ No Hemophilia/Abnormal Bleeding
☐ Yes ☐ No Anemia/Blood Disease
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Artificial Bones/Joints
☐ Yes ☐ No Cancer/Chemotherapy
☐ Yes ☐ No Radiation Treatment
☐ Yes ☐ No Chest Pain/Angina
☐ Yes ☐ No Psychiatric Problems
☐ Yes ☐ No Epilepsy or Seizures
☐ Yes ☐ No Fever Blisters
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Drug/Alcohol Abuse/Addiction
☐ Yes ☐ No Venereal Disease
☐ Yes ☐ No Kidney/Liver Problems
☐ Yes ☐ No Ulcers/Colitis
☐ Yes ☐ No Fainting
☐ Yes ☐ No Sinus Problems
☐ Yes ☐ No Asthma
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Emphysema
☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Tuberculosis (TB)
☐ Yes ☐ No Shingles
☐ Yes ☐ No Other________________________
☐ I would like to speak privately to the doctor.

MEDICATIONS/ALLERGIES

Please list all medications you have taken within the past year: ____

____

____

Are you allergic to the following?

☐ Yes ☐ No Penicillin
☐ Yes ☐ No Dental Anesthetic
☐ Yes ☐ No Latex
☐ Yes ☐ No Sulfa
☐ Yes ☐ No NSAIDS *(ex. ibuprofen)*
☐ Yes ☐ No Other Drugs________________

FINANCIAL POLICY (ACKNOWLEDGEMENT AND AUTHORITY)

Uninsured Patients: The total treatment fee is due and payable upon completion of treatment. Payments by cash, check, Visa, Mastercard, Discover and American Express are accepted.

Insured Patients: King Endodontics is an OUT-OF-NETWORK provider for all dental insurance plans. Patients should not expect their insurance to cover the full cost of treatment. A co-pay will be estimated and collected at the time of treatment. You will be billed for any balance remaining on your account after your insurance benefits have been applied. Once you account has been paid in full by your co-pay and insurance, any overpayments will be promptly refunded directly to you.

Root Canal Fee:___________________________________**50% of fee due at time of service**

Consultation Fee: _________________________________**Full fee due at time of service**

3D Scan (CBCT) Fee: ______________________________**Full fee due at time of sevice (if needed)**

Patient Signature *(Parent/Guardian of minor)*: **Date:**