



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

- | | | | | | |
|------------------------------|-----------------------------|------------------------------|------------------------------|--|------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Attack/Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric Problems |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy or Seizures |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fever Blisters |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Drug/Alcohol Abuse/Addiction |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Surgery/Pacemaker | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Venereal Disease |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Congenital Heart Defect | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney/Liver Problems |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Blood Transfusion | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcers/Colitis |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | HIV+/AIDS | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fainting |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis A, B, or C | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sinus Problems |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hemophilia/Abnormal Bleeding | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Asthma |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Anemia/Blood Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Glaucoma |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Emphysema |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Artificial Bones/Joints | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cancer/Chemotherapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis (TB) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Radiation Treatment | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shingles |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Chest Pain/Angina | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other_____ |
| | | | <input type="checkbox"/> | 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?

- | | | | | | | | | |
|------------------------------|-----------------------------|-------------------|------------------------------|-----------------------------|-------|------------------------------|-----------------------------|--------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Penicillin | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Latex | <input type="checkbox"/> Yes | <input type="checkbox"/> No | NSAIDS (ex. <i>ibuprofen</i>) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dental Anesthetic | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sulfa | <input type="checkbox"/> Yes | <input type="checkbox"/> 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 your 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 service (if needed)

Patient Signature (Parent/Guardian of minor): _____

Date: _____
