Hill Country Endodontics

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

ADULT PATIENT

NAME		
ADDRESS		
CITY	STATE	ZIP
HOME PHONE	CELL NO.	
OCCUPATION		
EMPLOYER	PHONE NO.	
BIRTHDATE	AGE	SEX
SOCIAL SECURITY NO.		
SPOUSE	OCCUPATION	

INSURANCE AND PAYMENT INFORMATION

NAME OF SUBSCRIBER	DOB
ADDRESS (if different from patient)	
SOCIAL SECURITY NO.	MEMBER NO.
RELATIONSHIP TO PATIENT	
EMPLOYER	PHONE NO.
INSURANCE NAME	
INSURANCE PHONE NO.	

CHILD PATIENT

NAME		
ADDRESS		
CITY	STATE	ZIP
HOME PHONE NO.		
BIRTHDATE	AGE	SEX

EMERGENCY CONTACT

PERSON TO CONTACT FOR EMERGENCY		
RELATIONSHIP		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

BE ADVISED THAT INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR AND IS NOT A SUBSTITUTE FOR PAYMENT. SOME COMPANIES PAY FIXED ALLOWANCES FOR CERTAIN PROCEDURES AND OTHERS PAY A PERCENTAGE OF THE CHARGE. IT IS **YOUR RESPONSIBILITY** TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE OR ANY OTHER BALANCE NOT PAID FOR BY YOUR INSURANCE COMPANY.

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Signature _____ Date _____

All signatures must be by parent or guardian if patient is under the age of 18

PATIENT DENTAL & MEDICAL HISTORY

How would you describe your health? **(Please circle one)** **Excellent** **Good** **Fair** **Poor**

Are you currently being treated for any illness or medical condition?.....Yes _____No_____

If yes, please describe_____

Who is treating you for this condition? **NAME** _____ **PHONE** _____

Have you ever had any kind of surgery?.....Yes_____No_____

If yes, Please list _____

Have you ever required a blood transfusion or blood thinner?..... Yes_____No_____

Do you require antibiotics (premed) before dental appointments?.....Yes_____No_____

Please list any medications you are currently taking: (If you carry a medication list, we will be happy to make a copy) _____

_____

Please specify any allergic or adverse reactions you have ever had to LATEX, anesthetics, antibiotics or any other medications. _____

PLEASE CIRCLE ANY PRESENT OR PAST ILLNESSES YOU NOW HAVE OR HAVE HAD IN THE PAST:

Heart murmur or prolapsed valve (MVP)	Thyroid problems	Hepatitis **A, B, or C**
Prosthetic heart valve	Joint prosthesis (hip, knee, etc.)	HIV / AIDS
Rheumatic fever or rheumatic heart disease	Diabetes	Cancer _____
Congenital heart disease	Stomach ulcers or Colitis	Radiation or Chemotherapy
Cardiovascular disease	Jaundice or Liver disease	Oral Herpes
Heart attack or Chest pain	Dialysis or Kidney problems	Depression or psychiatric disorder
Stroke or TIA	High Blood Pressure	(TMJ) joint problems
Bleeding disorder (e.g. Anemia)	Epilepsy, fainting spells or seizures	Asthma or sinus trouble

If female, are you pregnant? Yes____ No _____ what month? _____ are you nursing? Yes _____ No _____

Do you take birth control pills? Yes__ No __ **If yes, be advised that if you take antibiotics, an alternate method of birth control must be used.**

Is there any information we should know about your health? _____

Whom may we thank for referring you? _____

I HAVE REVIEWED THE INFORMATION, AND IT IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT THIS INFORMATION WILL BE USED BY THE DENTIST TO HELP DETERMINE APPROPRIATE AND HEALTHFUL DENTAL TREATMENT. IF THERE IS ANY CHANGE IN MY MEDICAL STATUS, I WILL INFORM THE DENTIST.

Signature _____ Date _____

All signatures must be by parent or guardian if patient is under the age of 18

Reviewed by Dr. Michael Schwarze _____ on ___/___/___

Reviewed by Dr. Karl Keiser _____ on ___/___/___

Reviewed by Dr. Neil Begley _____ on ___/___/___