Columbus Endodontic Specialists

Patient's Name: _____ Birth Date: _____

Patient's Home Address: _____ Home Phone: _____

City and Zip: _____ Work Phone: _____

Place of Employment: _____ Cell Phone: _____

Name of Spouse: _____ Where Employed: _____

Person Responsible for Patient's Account: _____

Name of Dental Insurance Company: _____

In Case of Emergency Contact: _____ Phone: _____

Name of Dentist Who Referred You: _____

HEALTH HISTORY

Name of Physician: _____ Date of Last Physical: _____

Please check (✓) any of the following diseases or problems which you have or have had:

☐ Rheumatic Fever
☐ Rheumatic Heart Disease
☐ Heart Trouble
☐ Heart Attack
☐ High Blood Pressure
☐ Mitral Valve Prolapse
☐ Asthma or Hay Fever
☐ Epilepsy (fainting spells or seizures)
☐ Thyroid Condition or Goiter
☐ Stomach Ulcers
☐ Kidney Trouble
☐ Emotional Difficulty
☐ Venereal Disease
☐ HIV infection/AIDS
☐ Sinus Trouble
☐ Hepatitis, Jaundice or Liver Disease
☐ Stroke
☐ Angina
☐ Diabetes
☐ Arthritis
☐ Allergies
☐ Tuberculosis
☐ Hives or Skin Rash
☐ Joint Replacement

Please check (✓) Yes or No for each question:

☐ Yes ☐ No 1. Are you in good health?
☐ Yes ☐ No 2. Are you under a physician's care?
☐ Yes ☐ No 3. Have you been hospitalized or had a serious illness within the last five years?
☐ Yes ☐ No 4. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?
☐ Yes ☐ No 5. Have you had surgery or x-ray treatment for a tumor, growth or other condition of your mouth or body?

6. Have you had any of the following within the last 6 months?

☐ Yes ☐ No Antibiotics or Sulfa Drugs
☐ Yes ☐ No Anticoagulants (blood thinners)
☐ Yes ☐ No Medicine for Blood Pressure
☐ Yes ☐ No Cortisone Steroids
☐ Yes ☐ No Tranquilizers
☐ Yes ☐ No Nitroglycerin, or other Drugs for Heart Trouble
☐ Yes ☐ No Insulin or Oral Medication for Diabetes
☐ Yes ☐ No Medication for Osteoporosis
☐ Yes ☐ No Other Medication? _____

7. Are you ALLERGIC to any of the following?

☐ Yes ☐ No Local Anesthetics
☐ Yes ☐ No Penicillin or other Antibiotics
☐ Yes ☐ No Barbiturates, Sedatives or sleeping pills
☐ Yes ☐ No Aspirin or Codeine
☐ Yes ☐ No Iodine or Latex
☐ Yes ☐ No Other? _____

8. Women are you:

☐ Yes ☐ No Pregnant
☐ Yes ☐ No Breastfeeding
☐ Yes ☐ No Using Oral Contraceptives or hormonal therapy

9. Do you have any other disease, condition, or problem not listed above that you think we should know about? ☐Yes ☐No

Explain: _____

I certify that I have accurately answered the above questions to the best of my knowledge. I consent to the performance of dental procedures agreed to be necessary including the use of local anesthetic as indicated, and I will assume responsibility for fees with those procedures.

Signature: _____ **SS#** _____ **Date:** _____