PERSONAL INFORMATION

COTTONWOOD ENDODONTICS, P.C.

Name (First) (Middle initial) (Last)

Address

City State Zip code

Telephone (Home) Date of Birth Sex

Telephone (Work) (cell) May we call you at work? ☐ Yes ☐ No

Social Security # (If necessary for insurance purposes) ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Email Address May we contact you via email? ☐ Yes ☐ No

May we send you a paperless billing statement to the above email address ? ☐ Yes ☐ No

Employer / Occupation Phone #

Person to notify in case of emergency Phone #

Who referred you to our office?

General Dentist Phone #

DENTAL INSURANCE INFORMATION

Insured Employee's Name Relationship to patient

Employee's Social Security # Date of Birth

Insurance Company Group #

Insurance Company Address Phone #

Are you covered by a secondary insurance company? ☐ Yes ☐ No

If yes, Secondary Insurance Company Group #

Insurance Company Address Phone #

Employee's Name Relationship to patient

Employee's Social Security # Date of Birth

If under 18 or full time student (Responsible Party Information)

Name (First) (Middle initial) (Last)

Address City State Zip code

Telephone (Home) (work) Social Security #

Please Complete Back Side

MEDICAL HISTORY

Please complete the following questions in order that we may thoroughly diagnose your condition. The information you provide is for our records and will be considered strictly confidential. In addition, it is your responsibility to update the medical history when any changes occur.

YES NO

1. Has there been any change in your health within the past year?..... ☐ ☐
Please specify _____

2. Are you in good health?..... ☐ ☐
If not, explain _____

3. Are you taking any medications or drugs?..... ☐ ☐
Please specify _____

4. Do you have any allergies to foods, medications, latex, or metals?..... ☐ ☐
If so, which ones? _____

5. Do you have or have you had any of the following? (Please check)

- ☐ High blood pressure
- ☐ Heart murmur or prolapsed valve (MVP)
- ☐ Joint prosthesis (hip, knee, etc.)
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Congenital heart disease
- ☐ Prosthetic heart valve
- ☐ Blood disorder (e.g. Anemia)
- ☐ Venereal disease
- ☐ Asthma
- ☐ Temporomandibular joint problems (TMJ)
- ☐ Sinus trouble
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Stomach ulcers or irritable bowel syndrome
- ☐ Colitis
- ☐ Hepatitis, jaundice, liver disease
- ☐ Psychiatric treatment
- ☐ Epilepsy, fainting spells or seizures
- ☐ Cancer
- ☐ HIV/Aids

6. Do You have a pacemaker and/or defibrillator ..... ☐ Yes ☐ No
7. Do you have any disease, condition or problem not listed above?..... ☐ Yes ☐ No

Women:

8. Are you pregnant?..... ☐ Yes ☐ No Are you nursing? ..... ☐ Yes ☐ No
9. Do you take birth control pills? ☐ Yes ☐ No
If YES, please be advised that if you take antibiotics, an alternate method of birth control must be used.

I understand as a service to me, the dental practice will assist me in processing my insurance claims, however, I am completely responsible for all fees in their entirety. All of the above information is true to the best of my knowledge.

Date _____ Signed (Patient of parent if minor) _____

I authorize the use of my radiographs and/or photographs for use in seminars or publications for the Doctor.

Date _____ Signed (Patient or parent if minor) _____