capitol endodontics

405 Capitol Street, Suite 914
Charleston, WV 25301
Phone: (304) 345-1248

PATIENT INFORMATION

Name ____ Today's Date ______________ Sex __________

Birthdate _________________________ Marital Status ____________________________ Age __________

SS# ___________________________________

Address ____

City ____ Zip_________________

Home Phone _____________________ Work Phone ____________________ Cell Phone ____________________

Email Address ____

Employer ____ Occupation ____________________________

Person responsible for account ____

Address & phone if different from the above information ____

____

Spouse's Name ____ Employer _________________________________

Work Phone ___________________________

In case of emergency, notify ____ Relationship ____________________

Emergency Contact Phone _____________________________

Family Physician ____

Family Dentist ____

Pharmacy ______________________________________ Phone and/or Location______________________________

I will be paying today by: ☐ Cash ☐ Check ☐ Visa ☐ Mastercard ☐ Care Credit

Name of Primary Dental Insurance Company: ________________	Name of Insured Person
	Date of Birth
	Name of Employer
	ID/SSN
Name of Secondary Dental Insurance Company: ________________	Name of Insured Person
	Date of Birth
	Name of Employer
	ID/SSN

Please complete the front and back of this form

HEALTH HISTORY

Have you ever had any of the following diseases or medical problems?
(Please read thoroughly and circle "Yes" or "No".)

Yes No Heart Attack / Stroke (Date: _____________)
Yes No Stroke (Date: _____________)
Yes No Bypass / Stent Surgery (Date: _____________)
Yes No Heart Valve (Artificial) (Date: _____________)
Yes No Rheumatic Fever
Yes No Heart Murmur
Yes No Hepatitis (A, B, or C?)
Yes No Anemia
Yes No High/Low Blood Pressure
Yes No Severe Headaches
Yes No Epilepsy/Seizures/Fainting Spells
Yes No Drug / Alcohol Abuse
Yes No Hemophilia/Abnormal Bleeding
Yes No Blood Transfusion
For Women: Pregnant? **Yes** No If yes, Week # ____

Yes No Root Canal Treatment
Yes No Cancer
Type & Treatment: _____________
Yes No HIV / AIDS
Yes No Shingles
Yes No Kidney Problems
Yes No Sinus Problems (Chronic)
Yes No Asthma
Yes No Psychiatric Care
Yes No Diabetes
Yes No Tuberculosis (TB)
Yes No Sickle Cell Disease
Yes No Fever Blisters / Cold Sores
Yes No Joint Prosthesis (Hips, Knee, Other?)
(Date Placed: _____________)

Have you ever experienced any serious medical conditions ***not*** listed above?
If yes, please list: ____

____

Are you currently under the care of any physician? (Other than routine visits) ◻ **Yes** ◻ No

If yes, please explain: ____

____

Are you presently taking any **medications** prescribed by a physician or dentist, or over the counter? ◻ **Yes** ◻ No

If yes, please list reason for taking each medication: ____

____

Have you ever taken **Bisphosphonates?** ◻ **Yes** ◻ No If yes, please circle which one.

(Fosamax, Fosamax Plus D, Zometa, Didronel, Reclast, Boniva, Actonel, Aclasta, Aredia, Atelvia, Skelid)

Are you **allergic** to the following drugs?
Yes No Penicillin
Yes No NSAIDs
Yes No Dental Anesthetics
Yes No Aspirin
Yes No Codeine
Yes No Other ____________________________________

Please list what happens when you experience the allergic reaction: ____________________________________

Are you allergic to **LATEX**? ◻ **Yes** ◻ No

Are you ***required*** to take **antibiotics prior to dental treatment** for artificial joints or heart defects? ◻ **Yes** ◻ No

WARNING: Birth control pills may be rendered ineffective by antibiotics.

Signature: ____ Date: __________________________

If under 18 years of age, parent / guardian must sign. Please list relationship: ________________________