

Welcome to



St. Croix Endodontics, PA

Patient Information

Date _____

Name _____ Sex: M F

Address _____ Home Phone _____

City _____ State _____ Zip _____

Soc Sec. # _____ Birthdate _____

Cell Phone _____ Minor Married Single Divorced Widowed

Employer _____ Work Phone _____

Spouse's Name _____ Birthdate _____

Emergency Contact _____ Phone _____

Person Responsible for Account _____

If student, name of college/school _____

Primary Insurance

Policy Holder's Name _____ Relationship _____

Birthdate _____ Soc. Sec. # _____

Employer _____ Insurance Company _____

Subscriber I.D. _____ Group # _____

Address _____ City _____ State _____ Zip _____

Secondary Insurance

Policy Holder's Name _____ Relationship _____

Birthdate _____ Soc. Sec. # _____

Employer _____ Insurance Company _____

Subscriber I.D. _____ Group # _____

Address _____ City _____ State _____ Zip _____

Medical History

Please take a few minutes to answer the following questions so we can better assist you with your health care needs.

Referring Dentist _____ Medical Doctor _____

Are you currently under medical treatment? If so, please describe _____

Are you currently taking any medications? If so, please list _____

Have you had any allergic reactions to the following? If yes, please list what kind and type of reaction, otherwise check No box.

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Local anesthetic (eg., novocaine) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other antibiotics _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Sulfa drugs _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates (eg., phenobarbital) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Sedatives (eg., Valium) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Iodine _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Metals _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

Please check the box if you have ever had the following?

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Blood disease |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur | <input type="checkbox"/> | <input type="checkbox"/> | Chemical dependency |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart problems | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Joint replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/Aids | <input type="checkbox"/> | <input type="checkbox"/> | Mitral valve prolapse |
| <input type="checkbox"/> | <input type="checkbox"/> | Back problems | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Do you need to be premedicated? |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Do you take oral contraceptives? |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? |

I certify that I have read and understand the above information and the questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care. To third party payers and/or health practitioners, I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier **may pay less** than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
Signature of patient or parent/guardian of minor

X _____
Doctor's Signature