Burleson ENDODONTICS

Welcome to Burleson Endodontics, please complete the forms to the best of your knowledge.
If you are a returning patient please verify that all the information is correct.
If you are unsure about a question, please ask.

PATIENT INFORMATION

Patient ID #:_____

Name:_____DOB:_____SSN: _____

Home Tel.:_____ Cell:_____E-mail: _____

Mailing Address: _____
Street City State Zip

Emergency Contact:_____Tel:_____Relation:_____

Referred By: _____Preferred Pharmacy:_____ Tel:_____

Employer:_____Occupation:_____Bus. Tel:_____

Employer's Address: _____
City State Zip

Dental Insurance Information

Primary Ins. Co. Name:_____Phone: _____

ID # or SSN:_____DOB:_____Group#:_____

Insured's Name:_____Relation:_____Employer:_____

Secondary Insurance (if applicable): _____

Dental History

Dentist Name/Office Name: _____ Last check-up:_____

Reason for today's visit: _____Are you in pain?_____

Please explain symptoms: _____

Have you or a family member be a patient of our practice? YES ☐ NO ☐

Patient Name:_____

Medical History

Primary Care Physician Name: _____ Office Name:_____

Office Tel #:_____ Last appointment date:_____

Secondary Care Physican Name: _____Office Name: _____

Office Tel #:_____ Last appointment date:_____

Height:_____Weight:_____. Are you under the care of a physician? ❑ Yes ❑ No

Has a physician recommended that you take antibiotics prior to your dental treatment? ❑ Yes ❑ No

Have you had any illness, operation, or been hospitalized in the past five years? ❑ Yes ❑ No

Have you ever been sedated (ex: nitrous, conscious, general anesthesia)? ❑ Yes ❑ No

- Any adverse reactions? _____

To the best of your knowledge, do you have, or have you recently had, any of these conditions? (Check each item that applies):

High/Low Blood Pressure	□	Fatigue	□
Heart attack, condition, surgery or disease	□	Osteoporois/Osteopenia	□
Rheumatic fever, heart murmur, congenital disease	□	Ulcers, stomach problems	□
Stroke	□	AIDS, or +HIV test	□
High or low blood sugar, diabetes	□	Asthma, hay fever	□ Last asthma attack_____
Lung disease, TB, Bronchitis, or emphysema	□	Blood transfusion	□
Allergy to Latex (rubber)	□	Kidney trouble or Dialysis	□
Chronic sinus problems	□	Venereal disease	□
Are you taking any herbal medicines?	□	Do you drink alcohol daily?	□
Prolonged bleeding/Anemia	□	Epilepsy, seizures, convulsions	□
Do you use Tobacco	□	Taking blood thinners, coumadin	□
Glaucoma	□	Embolism	□
Depression or anxiety	□	Treatment for TMJ	□
Taking diet pills (Redux, Phen Fen)	□	Thyroid/ gland problems:	hypo □ hyper □
Migraine/Frequent Headaches	□	Sleep Apnea	□
Cancer Treatment, Tumors	□	Pacemaker	□
Previous Endocarditis	□	Herpes	□
Joint Replacement/Prosthetic Implant	□	Hepatitis	□
Psychiatric Care/Mental	□	Glaucoma/visual care	□
Cancer, Radiation, Chemotherapy	□	Jaundice/Liver Disease.	□

-Are you currently taking or have you previously taken bisphosphonate medications, such as Actonel, Fosamax, Zometa, orDenosumab, Bevacizumab, Forteo or Raloxifene(Evista) within the past 12 years? YES NO

For Women:

Pregnant or possibility of being pregnant? YES NO How far along? _____ Are you nursing? YES NO

Are you nursing? YES NO Taking a form of birth control? YES NO

Patient Name:_____

Medications

Please provide a list of all current medications and reason for taking, continue to back page if needed.

Medication	Reason

Allergies

Please check mark any medication/substance that the patient has an allergy or sensitivity

Aspirin	□	Tylenol	□
Local Anesthetic	□	Latex	□
Gutta Percha	□	Valium	□
Shell fish	□	Nitrile	□
EDTA	□	Ethanol	□
Penicillin	□	Nitrous	□
Sulfa/Sulfites	□	Narcotics	□
Ibuprofen	□	Codeine	□
Bleach	□	Iodine	□
Antibiotics	□	Food	□
*- list:*_____		*-list:*_____	

Any other:_____

Surgery History

Please list any surgeries and date of surgical procedure.

Type: _____ Date:_____
Type: _____ Date:_____
Type: _____ Date:_____
Type: _____ Date:_____
Type: _____ Date:_____

Any complications from any of these procedures?

_____
_____
_____
_____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

(-parent or guardian sign if minor)

1st Visit: Patient Signature:_____ Date:_____

Treating Doctor:_____Date:_____

2nd Visit: Patient Signature:_____ Date:_____

- *No changes in Med Hx/medications*

Treating Doctor:_____ Date:_____

3rd Visit Patient Signature:_____Date:_____

- *No changes in Med Hx/medications*

Treating Doctor:_____ Date:_____