Naperfield Endodontics, P.C.
Patient Information for Treatment (Confidential)

Patient Name: Date:
Spouse Name: Single_____ Married_____
Address:
City: State: Zip:
Home Phone: Work Phone: Cell Phone:
Birth Date: Age: Male_____ Female____
Social Security# (for billing and insurance purposes):
Emergency Contact: Phone: Relationship:

Referred to us by:
Name: Phone:
Address:
Reason for Referral:

Medical History: Answer yes or no for each question:
Are you generally in good health? Date of last medical exam:
Do you have or have you ever had any of the following?

Rheumatic Fever	Yes	No	Stomach Problems	Yes	No
Heart Murmur	Yes	No	Multiple Sclerosis	Yes	No
Mitral Valve Prolapse	Yes	No	Arthritis	Yes	No
Prosthetic Heart Device	Yes	No	Organ Transplant	Yes	No
Pacemaker	Yes	No	Osteoporosis	Yes	No
Abnormal Heart Condition	Yes	No	Long Term Steroid Use	Yes	No
High Blood Pressure	Yes	No	Psychological Disorder	Yes	No
Low Blood Pressure	Yes	No	Hepatitis	Yes	No
Pulmonary or Lung Disease	Yes	No	Tuberculosis	Yes	No
Bleeding Disorders	Yes	No	Syphilis	Yes	No
Anemia	Yes	No	Herpes	Yes	No
Liver Problems	Yes	No	HIV/AIDS	Yes	No
Kidney Problems	Yes	No	Sinus Problems	Yes	No
Diabetes	Yes	No	Cancer	Yes	No
Asthma	Yes	No	Artificial Joint	Yes	No
Prosthetic Implants	Yes	No	Radiation or Chemo	Yes	No
Thyroid Problems	Yes	No	Do you use Tobacco	Yes	No

Have you ever used any Bisphosphonate products, i.e. Fosamax? Yes No

Any other Medical Condition?

Are you allergic to any of the following?
Latex___ Iodine___
Penicillin___ Sulfa Drugs___
Local Anesthetic___ Other Allergies____________
Do you require pre medication with antibiotics prior to dental work? Yes No

For women: Are you pregnant or think you might be pregnant? Yes No
If yes, how far along are you in your pregnancy?
Are you nursing? Yes No
List all medications you are currently taking, both prescription and over the counter:

Name of your physician: ____ Phone#______________________

Dental History:

Have you ever had a root canal therapy? Yes No
If yes, how was your experience? Good Fair Poor
Are you currently in pain from a tooth? Yes No
Have you seen your general dentist for a comprehensive dental exam and treatment plan in the past year? Yes No
Have you had your dental cleaning done in the past six months? Yes No
Do you have or ever had periodontal (gum) disease? Yes No
Do you have a history of teeth grinding? Yes No
Do you have TMJ disorder? Yes No

Primary Dental Insurance Account Information:

Name of person financially responsible for account:
Relationship to patient: Date of Birth:
Address:
City: State: Zip:
Home Phone#: Work Phone#:
Occupation: Employer:
Business Address:
City: State: Zip:
Insurance Company:
Group#:_________________________ Account I.D. #_____________________________
Social Security #:__________________________________

Secondary Dental Insurance (if any):

Account Holder Name: Date of Birth:_____________
Relationship to Patient:
Address:
City: State: Zip:
Insurance Company:
Group#:__________________________ Account I.D. #_____________________________
Social Security #:__________________________________

Patient or Guardian Signature ____Date____________

Medical History Updates (to be completed by Doctor):

Date:
Update:
Signature:

Date:
Update:
Signature:

Examiner's Review

Date:

Signature: