Utah Valley ENDODONTICS

The following information is needed in it's entirety for our records.
Please **PRINT** your answers on **BOTH** sides of the form.

PATIENT INFORMATION

Full Name _____

Phone: Home_____ Work _____ Cell _____

Address _____ City _____ State _____ Zip _____

Social Security #_____Date of Birth _____Age _____

Gender _____ Marital Status _____ Spouse's Name_____

Emergency Contact (Not living with you): _____ Phone #_____

NAME OF GENERAL DENTIST_____

RESPONSIBLE PARTY

Person Responsible for Account _____ Social Security # _____

Relation to Patient _____ Date of Birth _____

Phone: Home _____ Work _____ Cell _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Employer_____ Location _____

INSURANCE INFORMATION

****IMPORTANT: THIS SECTION MUST BE COMPLETELY FILLED OUT OR WE WILL NOT BILL YOUR INSURANCE****

Primary Dental Insurance _____ Employer _____

Policy Holder _____ Date of Birth _____

Social Security # or Insurance ID # _____ Group # _____

Insurance Address _____

Street City State Zip

Insurance Company Telephone # _____

IF APPLICABLE:

Secondary Dental Insurance _____ Employer _____

Policy Holder _____ Date of Birth _____

Social Security # or Insurance ID # _____ Group # _____

Insurance Address _____

Street City State Zip

Insurance Company Telephone # _____

State the purpose of your visit _____

Medications you are taking and the reason for each _____

_____

Are you now under a physician's care, or have you been during the past five years*? ☐ YES ☐ NO

(*Specifically hospitalization(s) and surgery)

If so, for what reason _____ Name of Physician _____

Please list any allergies or sensitivity you may have to any drugs or medications

(Such as penicillin, Novocain, aspirin, codeine, sulfa, acetaminophen, ibuprofen etc.)

_____

Have you ever had any severe reaction to dental treatment or local anesthetics? ☐ YES ☐ NO

If YES, please describe? _____

Does your physician require that you take an antibiotic for **premedication*** 1 hour prior to dental treatment? ☐ YES ☐ NO

(***Due to heart condition, artificial valve or artificial joint, etc**.)

If, YES, have you premedicated for your appointment today? ☐ YES ☐ NO

DO YOU CURRENTLY HAVE OR HAD A HISTORY OF THE FOLLOWING:

	Y	N		Y	N		Y	N
Heart Trouble/Disease			Radiation Treatments			Anemia		
Heart Murmur			Thyroid Disease			Herpes		
Angina or Heart Attack			Diabetes			HIV/AIDS		
Rheumatic Fever			Kidney Disease			Hepatitis A or B or C		
Pacemaker			High Blood Pressure			Tuberculosis		
Stroke			Low Blood Pressure			Smoking		
Jaundice			TMJ Problems			Asthma		
Artificial Joints			Difficulty Opening Mouth			Emphysema		
Seizures			Blood Transfusion			Pneumonia		
Epilepsy			Prolonged Bleeding			Chronic Cough		
Fainting Spells			Easy Bruising			Lung Disorder		
Nervous Disorders			Psychiatric Treatment			Shortness of Breath		
Convulsions			Liver Disease			Taken Phen-Fen		
Sinus or Nasal Problems			Stomach Ulcers/Colitis			Latex Allergy		
Arthritis			Transplant Operations			OTHER: _____		

WOMEN: ARE YOU OR IS THERE A CHANCE THAT YOU ARE PREGNANT? ☐ YES ☐ NO

To the best of my knowledge, all of the preceding answers are true and correct.

_____ _____

Name of Patient (PLEASE PRINT) **Doctor's Signature**

_____ _____ _____

Signature of Patient, Parent or Guardian **Date** **Relationship to Patient**