Charleston Endodontics Patient History

Patient Information *Please circle YES or NO*

Patient Name: _____

Nickname: _____

General Dentist: _____

Please circle answer:

Sex: M F Marital Status: S M D W

Patient D.O.B.:_____ Age: _____

Mobile #:_____ Home #: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ Employer: _____

Occupation: _____Work #: _____

Spouse / Parent / Guardian Name: _____

Parent / Guardian D.O.B.: _____ Phone #: _____

Patient Insurance *Please circle YES or NO*

Primary Dental Insurance: _____

Please circle answer:

Relationship to Insured: Self Spouse Child Other

Insured SSN: _____

Insured Birth Date: _____

Employer: _____

Secondary Dental Insurance: _____

Please circle answer:

Relationship to Insured: Self Spouse Child Other

Insured SSN: _____

Insured Birth Date: _____

Employer: _____

Patient Health History *Do you have or have you ever had any of the following? Please circle YES or NO*

YES NO Heart Attack / Stroke

YES NO Artificial Joints / Limbs DATE PLACED:_____

YES NO Heart Murmur / Rheumatic Fever

YES NO Heart Surgery / Pacemaker DATE: _____

YES NO Congenital Heart Disorder / Mitral Valve Prolapse

YES NO Anemia

YES NO High / Low Blood Pressure

YES NO High / Low Cholesterol

YES NO Severe Headaches / Migraines

YES NO Asthma / Breathing Problem / Emphysema / COPD

YES NO Epilepsy / Seizures / Fainting Spells

YES NO TMJ / (Jaw Joint) Problems / Clench or Grind

YES NO Daily Aspirin or Blood Thinner

YES NO Dental Anxiety

Are you required to take Antibiotics / Premed prior to Dental treatment due to a heart issue or joint / valve replacement?

If YES – For What? _____

Any other health issue not listed above: _____

YES NO Hemophilia / Abnormal Bleeding

YES NO Blood Transfusion

YES NO Cancer / Chemotherapy / Radiation

YES NO HIV+ / AIDS

YES NO Tuberculosis (TB)

YES NO Hepatitis *Circle One* A B C

YES NO Shingles

YES NO Kidney Problems

YES NO Sinus Problems / Seasonal Allergies

YES NO Diabetes

YES NO Arthritis / Joint Disease

YES NO Thyroid Disease

YES NO Drug / Alcohol Abuse

YES NO Osteoporosis / Osteopenia

YES NO Have you ever taken a Bisphosphonate for osteoporosis?
How long have you taken it? Or been off of it?_____

If Pregnant Week #: _____

Are You Allergic To The Following
Please circle YES or NO

YES NO Latex

YES NO Dental Anesthetic

YES NO Penicillin

YES NO Codeine

Any other allergies: _____

List or provide a list of all current medications

_____

_____

_____

Name of Pharmacy / Location: _____ Pharmacy Phone #: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office staff of any medical changes.

Signature: _____ Date: _____