

Referring Dr. _____
(Administrative use only)

PATIENT INFORMATION

Name _____
Last First Middle Initial

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Birthdate _____ Social Sec # _____

If patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Responsible Party Information

Name _____
Last First Middle Initial Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address? _____ Home Phone _____ Work Phone _____

Social Sec. # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____

(Primary or Secondary Insurance Holders Information)

Spouse's Name _____ Relationship to Patient _____
Last First M.I.

Employer _____ Occupation _____

Social Sec. # _____ Birthdate _____ Work Phone _____

Insurance Information

Primary Insurance

Name of Company _____
Address _____

Group Num. _____ Local # _____

Secondary Insurance

Name of Company _____
Address _____

Group Num. _____ Local # _____

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish to emphasize that as Dental Care Providers, our relationship is with you, not your insurance company. All charges are your responsibility from the date the services are rendered. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies. Dental insurance, by design, is usually meant to be an aid rather than pay-all. Unlike major medical insurance, the amount (co-payment) or remaining balance, less what the insurance company pays, is typically higher. We do not believe that it is in your best interest to base your treatment on the limitations of your particular insurance program.

Emergency Contact Information

Name _____ Relationship to patient _____
Last First M.I.

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Other _____

Health History

These questions are *confidential* and help us provide better care.

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Are you in good health?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you seen a physician in the last 2 years?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have any allergies?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If yes, please list</i> _____ | | |
| 4. Have you had an unfavorable reaction to dental treatment?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If yes, please specify</i> _____ | | |
| 5. Have you ever had excessive bleeding requiring special treatment?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any other serious illness?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If yes, please list</i> _____ | | |
| 7. If female, are you or might you be pregnant? Which month?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you nursing?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you in a high risk group for infectious diseases?..... | <input type="checkbox"/> | <input type="checkbox"/> |

9. Please indicate any of the following illnesses you have had:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head Injuries |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Condition/Disease | <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Condition/Disease | <input type="checkbox"/> Hepatitis (Type_____) | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Liver |
| <input type="checkbox"/> Cancer (Type_____) | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Kidney Condition/Disease | <input type="checkbox"/> Drug History | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Ulcers or Colitis | <input type="checkbox"/> Growths |
| <input type="checkbox"/> Major surgeries _____ | | | |
| <input type="checkbox"/> Other _____ | | | |

11. Are you taking any of the following?
- | | | |
|---|---|---|
| <input type="checkbox"/> Meds for High Blood Pressure | <input type="checkbox"/> Anitbiotics/Sulfa Drugs | <input type="checkbox"/> Anitcoagulants(Thinners) |
| <input type="checkbox"/> Insulin, Tolbutamide or similar drug | <input type="checkbox"/> Cortisone(Steroids) | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Nitroglycerin | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Digitalis or drugs for heart |
| | <input type="checkbox"/> Bisphosphonates (like Fosamax) | |
- Please list all medications that you take:** _____
- _____
- _____

12. Name of your general physician _____

Date

Asst. Int. for Med Hx Review

Doctor's Signature

The information provided is correct to the best of my knowledge. This includes any medical history and insurance information. I understand it is my responsibility to inform this office of any change in my medical and insurance history status.

- In order to process your insurance claims, we will need your signature to release payment.
- I authorize release of any information relating to any claim for services rendered to me or my dependents.
- I assign and request your company to pay directly to the doctors of Oregon Endodontic Group insurance benefits otherwise payable to me or my dependents.
- I understand I am financially responsible to Oregon Endodontic Group for charges not covered by this assignment.
- A delinquent account may be referred to a collection agency.

Patient Signature _____ Date _____

(If minor, parent's or guardian's signature)

TELL US ABOUT YOUR SYMPTOMS

Date _____

- 1. Are you experiencing any pain at this time? If not, please go to question 6. Yes No
- 2. If yes, can you locate the tooth that is causing the pain? Yes No
- 3. When did you first notice the symptoms? _____
- 4. Did your symptoms occur suddenly, or gradually? _____
- 5. Please check the frequency and quality of the discomfort, and the number that most closely reflects the intensity of your pain:

LEVEL OF INTENSITY

(on a scale of 1 to 10)

1=mild 10=severe

1__2__3__4__5__6__7__8__9__10__

FREQUENCY

- Constant
- Intermittent
- Momentary
- Occasional

QUALITY

- Sharp
- Dull
- Throbbing

Is there anything you can do to relieve the pain?

If yes, what? _____

Yes No

Is there anything you can do to cause the pain to increase?

If yes, what? _____

Yes No

When eating or drinking, is your tooth sensitive to:

Heat

Cold Sweets

Does your tooth hurt when you bite down, or chew?

Yes No

Does it hurt if you press the gum tissue around the tooth?

Yes No

Does a change in posture cause your tooth to hurt?

Yes No

(lying down or bending over)

- 6. Do you grind, or clench your teeth? Yes No
- 7. If yes, do you wear a night guard? Yes No
- 8. Has a restoration (filling or crown) been placed on this tooth recently? Yes No
- 9. Prior to today, has root canal therapy been started on this tooth? Yes No
- 10. Is there anything else we should know about your teeth, gums or sinuses that would assist us in our diagnosis? Please explain: _____

Assistant Notes: _____
