Beaches Endodontics
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# WELCOME TO BEACHES ENDODONTICS

## PATIENT INFORMATION

| | |
|---|---|
| Patient name: | Patient's SS#: |
| (Nickname): | Occupation: |
| Address: | Employer: |
| City: State: Zip: | Insurance provider: |
| General Dentist: | |
| Referred by: | **Below information for Insurance purposes only** |
| Male: ☐ Female: ☐ Married: ☐ Single: ☐ | Spouse/Parent/ |
| DOB: Age: | Guardian name: |
| Cell phone number: | DOB: |
| E-mail: | Spouse/Parent/Guardian SS#: |
| Emergency contact: | Spouse/Parent/ |
| Phone: | Guardian Employer: |

## CHECK ANY SYMPTOMS OR CONDITION(S) BELOW THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR

| | | | | |
|---|---|---|---|---|
| ☐ Arthritis | ☐ Depression | ☐ Hepatitis☐A☐B☐C | ☐ Migraine Headache | ☐ Stroke |
| ☐ Asthma | ☐ Diabetes | ☐ Hives/Rash | ☐ Mitral Valve | ☐ Thyroid |
| ☐ Bleeding Disorder | Type ☐ I ☐ II | ☐ HIV Positive | Prolapse | Problems |
| ☐ Bruise Easily | ☐ Emphysema | ☐ Hip/Joint | ☐ Multiple Sclerosis | ☐ Tuberculosis |
| ☐ Cancer | ☐ Epilepsy | Replacement | ☐ Neuralgia | ☐ Ulcers |
| ☐ Chemical Dependent | ☐ Hay Fever | ☐ Irregular Heartbeat | ☐ Pacemaker | ☐ Other |
| ☐ Chest Pain | ☐ Heart Disease | ☐ Jaundice | ☐ Prostate Problems | _____ |
| ☐ Cold Sores | ☐ High Blood | ☐ Kidney Disease | ☐ Rheumatic Fever | |
| ☐ Chronic Sinus | Pressure | ☐ Liver Disease | ☐ Scarlet Fever | ☐ **No Health** |
| Problems | | | | **Concerns** |

## ALLERGIES AND MEDICATIONS

**Are you ALLERGIC to any of the following?**

☐ Latex
☐ Penicillin
☐ Sulfa Drugs
☐ Aspirin
☐ Codeine
☐ Any Dyes
☐ **No Known Drug Allergies**

☐ Any Other Medications
_____
_____
_____
_____

**Medications that you are currently taking:**

☐ Not Taking Any Medications
_____
_____
_____
_____

By signing below you acknowledge that the above information is accurate to the best of your knowledge.

Patient (or Parent/Guardian) Signature | Patient (or Parent/Guardian) Printed Name | Date

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