Sudbury Endodontics, P.C.

111 Boston Post Road, Suite 215 • Sudbury, Massachusetts 01776

PLEASE PRINT

Referred by _____

General Dentist _____

PATIENT INFORMATION:

Title _____ First Name _____ Last Name _____

Preferred Name _____

Street Address _____

City _____ State _____ Zip Code _____

Home Phone # _____-_____-_____ Bus Phone # _____-_____-_____

Cell Phone # _____-_____-_____ Email _____

Sex _____ Date of Birth _____/ _____/_____ SS# _____ - _____ - _____

Occupation _____

Person to contact in case of emergency _____

Relationship and phone # _____

IS SOMEONE ELSE RESPONSIBLE FOR PAYMENT OF THE ACCOUNT? _____

If so, please complete the following:

Title _____ First Name _____ Last Name _____

Street Address _____

City _____ State _____ Zip Code _____

Phone #'s Home: _____-_____-_____ Cell: _____-_____-_____Bus: _____-_____-_____

DO YOU HAVE DENTAL INSURANCE? YES ____ NO _____ IF YES,

Insurance Company _____

Primary Subscriber Name _____ Relationship to Patient _____

Date of Birth _____ Employer _____

ID# _____ Group or Plan# _____

Secondary Subscriber Name _____ Relationship to Patient _____

Date of Birth _____ Employer _____

ID# _____ Group or Plan# _____

Date_____

CONFIDENTIAL MEDICAL HISTORY

Name, Address, phone # of Physician _____

_____

_____

Are you now or have you recently been under the care of a Physician? _____

For what have you recently been hospitalized? _____

_____

Do you have any serious illness? _____

_____

Do you have any allergies or adverse reactions to any of the following medications?
Please check the appropriate box:

	YES	NO		YES	NO
penicillin	❑	❑	nsaids (Ibuprofen, Motrin, Advil)	❑	❑
latex	❑	❑	codeine	❑	❑
aspirin	❑	❑	local anesthesia	❑	❑

other antibiotics _____

Are you currently taking oral contraceptives? ❑ ❑

Are you currently taking any medications? ❑ ❑

_____

_____

_____

Do you have any bleeding problems? ❑ ❑

Are you pregnant or nursing? ❑ ❑

Have you in the past or are you presently being treated for any infectious diseases? ❑ ❑

Please indicate by checking the appropriate box if any of the following pertain to you in any way, past or present: Please check yes or no.

	yes	no		yes	no		yes	no
Rheumatic fever	❑	❑	Artificial joint/valve	❑	❑	High blood pressure	❑	❑
Anemia	❑	❑	Nervous condition	❑	❑	Ulcers	❑	❑
Stroke	❑	❑	Recreational drug use	❑	❑	Kidney disease	❑	❑
Asthma	❑	❑	Hepatitis/liver disorder	❑	❑	Colitis	❑	❑
Seizures	❑	❑	Tuberculosis	❑	❑	Sinusitis	❑	❑
Thyroid treatment	❑	❑	Psychiatric care	❑	❑	Sexually transmitted		
Diabetes	❑	❑	AIDS/ARC/HIV positive	❑	❑	disease	❑	❑
Hepatitis	❑	❑	Chemotherapy	❑	❑	Blood transfusion	❑	❑
Arthritis	❑	❑	Heart problems	❑	❑	Blood disease	❑	❑
Hip replacement	❑	❑	Heart murmur	❑	❑	Radiation therapy	❑	❑
Knee replacement	❑	❑	Mitral valve prolapse	❑	❑	Organ transplant	❑	❑

other _____

_____

_____

Patient Signature: _____ Date:_____

reviewed by: _____ Date:_____