Date (M/D/Y) _____

GEORGETOWN
ENDODONTICS

Welcome To Our Office
In order to aid in evaluating your dental health thoroughly and completely, please complete the following examination questionnaire. This will become part of your office record and will be held in strict confidence.

Patient Information:

☐ Mr. ☐ Mrs. ☐ Ms. _____ (First Name) _____ (Initial) _____ (Last Name) _____ (Date of Birth (M/D/Y))

Address _____ Apt. _____ City _____ Postal Code _____

Home Tel ( ) _____ Cell ( ) _____ E-mail _____

Occupation _____ Employer _____ Business Tel ( ) _____

Insurance Information:

Primary Policy Holder Name _____ Policy Holder's D.O.B. (M/D/Y) _____

Insurance Company Name _____ Policy/Group# _____ ID# _____

Secondary Policy Holder Name _____ Policy Holder's D.O.B. (M/D/Y) _____

Insurance Company Name _____ Policy/Group# _____ ID# _____

Name of Spouse/Parent _____ Business Tel ( ) _____

Family Doctor _____ Tel ( ) _____ Referring Dentist _____

Have you ever had an unfavourable reaction following dental treatment? **YES / NO**
Please discuss this with the doctor.

Have you ever had excessive bleeding requiring special treatment? **YES / NO**

Please discuss this with the doctor. **YES / NO**

Female patients, are you or could you be pregnant or nursing? **YES / NO**

If pregnant, which month? _____

List of Allergies

_____

List of Medications & Reason
(include non-prescription drugs)

_____

Check off any of the following which you have or have had:

☐ Heart trouble/Angina	☐ High blood pressure	☐ Stomach ulcer
☐ Heart murmur	☐ Anemia	☐ Kidney disease
☐ Asthma	☐ Rheumatic fever	☐ Fainting spells
☐ Diabetes	☐ Lupus	☐ Sinus trouble
☐ Arthritis	☐ Nervous disorders	☐ Neck injury
☐ Jaundice	☐ Cortisone treatment	☐ Cancer treatment
☐ Stroke	☐ Psychiatric treatment	☐ Sickle cell disease
☐ Hemophilia	☐ Migraine/Headaches	☐ Liver disease
☐ Epilepsy	☐ Emphysema	☐ Thyroid disease
☐ Glaucoma	☐ Herpes	☐ Alcoholism
☐ Hepatitis A	☐ Hepatitis B	☐ Mitral valve prolapsed
☐ Addictions	☐ Venereal disease	☐ Artificial valve, joint/prosthesis
☐ TMJ problems	☐ Congenital heart defect	☐ Blood transfusion
☐ HIV+/Aids	☐ Cardiac pacemaker	☐ Tuberculosis (TB)

Do you have or have you had any other diseases or medical problems not listed on this form? _____

Dental History:

Are you presently in pain? **YES / NO**

Is any part of your mouth sensitive to the following? **YES / NO**

☐ Hot ☐ Cold ☐ Biting Pressure ☐ Sweets
☐ Other _____

Primary complaint: _____

_____

_____

Financial Policy. The major objective of our office is to provide you with the highest quality dental care. Our service is based on a friendly, mutual, but businesslike understanding between doctor and patient. We feel that misunderstanding can be minimized if financial policies are agreed upon at the beginning of treatment.

I hereby state that the above medical history is to the best of my knowledge, accurate and complete. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs or other diagnosticmeasures appropriate for a thorough evaluation.

_____ Signed

_____ Date