HANOVER ENDODONTICS CONFIDENTIAL PATIENT INFORMATION

Please print and fill out form completely. Thank you.

Date:______________________ Have you been pre-medicated? ☐ YES ☐ NO

PATIENT INFORMATION

Patient Name: ______________________ Date of Birth: ______________________

Male ☐ Female ☐ Social Security #: ______________ Occupation: ______________

Street Address: ______________________ Apt/Floor: ______________

City: ______________________ State: __________ Zip: __________

Home Phone: ______________________ Alternate Phone: ______________________

Email Address: ____

Whom may we thank for referring you?____

Who is your General Dentist? ____

Emergency Contact Name:______________________ Contact Phone:______________________

Are you a student? ☐ YES ☐ NO *If yes, please complete the following line:*______________________

College/School Name:______________________ City/State: ______________________

Is the patient a MINOR? ☐ YES ☐ NO *If yes*, please provide parent/guardian name: ______________________

Payment is expected at the time of service and may be made by the following:

☐CASH ☐PERSONAL CHECK ☐DISCOVER ☐MASTERCARD ☐VISA

DENTAL INSURANCE INFORMATION

Subscriber Name: ______________________ Relationship to Patient: ______________________

Subscriber's DOB: ______________________ Subscriber's SS#: ______________________

Employer: ______________________ Employment Date: __________ Work Phone:______________

Insurance Company Name: ____

Subscriber ID #: ______________________ Group #: ______________________

Insurance Co. Address:______________________ City/State: ______________ ZIP:__________

Secondary Dental Insurance Information (If Applicable)

Subscriber Name: ______________________ Relationship to Patient: ______________________

Subscriber's DOB: ______________________ Subscriber's SS#: ______________________

Employer: ______________________ Employment Date: __________ Work Phone: ______________

Insurance Company Name: ____

Subscriber ID #: ______________________ Group #: ______________________

Insurance Co. Address: ______________________ City/State: ______________ ZIP: __________

PERSON RESPONSIBLE FOR PAYMENT

Name: ______________________ Relationship to Patient:______________________

Street Address: ______________________ City/State:______________ ZIP: __________

Home Phone: ______________________ Alternate Phone: ______________ Email:______________

Birthdate: ______________Social Security #______________ Driver's license #______________

Employer: ______________________ Work Phone: ______________________

PATIENT SIGNATURE: ______________________ **DATE:** ______________________

HANOVER ENDODONTICS CONFIDENTIAL PATIENT INFORMATION

PATIENT MEDICAL HISTORY

Patients Name: ______________________ Date: ______________

Name of Physician: ______________________ Phone: ______________

Date of Last Visit: __________ Reason for Last Visit: ______________________

Your current physical health is? ☐ GOOD ☐ FAIR ☐ POOR

Are you taking any medications? ☐ YES ☐ NO

If yes, please list: ______________________

Have you ever taken Phen-Fen, Redux, or Pondimin? ☐ YES ☐ No If yes, when? __________

Are you currently taking aspirin? ☐ YES ☐ NO Are you taking herbal supplements? ☐ YES ☐ NO

Are you pregnant? ☐ YES ☐ NO Week #: __________ Are you on birth control? ☐ YES ☐ NO

Have you ever had any of the following diseases or medical problems?

Condition		Condition		Condition	
AIDS	☐ YES ☐ NO	Drug Abuse	☐ YES ☐ NO	Knee Replacement	☐ YES ☐ NO
Alcohol Abuse	☐ YES ☐ NO	Emphysema	☐ YES ☐ NO	Joint Replacement	☐ YES ☐ NO
Anemia	☐ YES ☐ NO	Epilepsy	☐ YES ☐ NO	Liver Disease	☐ YES ☐ NO
Arthritis	☐ YES ☐ NO	Fainting	☐ YES ☐ NO	Mitral Valve Prolapse	☐ YES ☐ NO
Asthma	☐ YES ☐ NO	Heart Attack	☐ YES ☐ NO	Pacemaker	☐ YES ☐ NO
Bleeding Problems	☐ YES ☐ NO	Heart Murmur	☐ YES ☐ NO	Radiation Treatment	☐ YES ☐ NO
Blood Transfusion	☐ YES ☐ NO	Heart Surgery	☐ YES ☐ NO	Rheumatic Fever	☐ YES ☐ NO
Breathing Problems	☐ YES ☐ NO	Heart Valve Replacement	☐ YES ☐ NO	Seizures	☐ YES ☐ NO
Cancer/Chemotherapy	☐ YES ☐ NO	Hemophilia	☐ YES ☐ NO	Sinus Problems	☐ YES ☐ NO
Colitis	☐ YES ☐ NO	Hepatitis	☐ YES ☐ NO	Steroid Therapy	☐ YES ☐ NO
Congenital Heart Defect	☐ YES ☐ NO	High Blood Pressure	☐ YES ☐ NO	Subacute Bact Endocarditis	☐ YES ☐ NO
Defibrillator	☐ YES ☐ NO	Hip Replacement	☐ YES ☐ NO	Thyroid Treatment	☐ YES ☐ NO
Diabetes	☐ YES ☐ NO	HIV	☐ YES ☐ NO	Ulcers	☐ YES ☐ NO
Dizzy Spells	☐ YES ☐ NO	Kidney Problems	☐ YES ☐ NO	Other? Please specify	☐ YES ☐ NO

Do you have any other medical conditions? If so, please list: ______________________

Have you had any recent hospitalizations? If so, when? ______________________

Are you allergic to any of the following:

Allergen		Allergen		Allergen	
Aspirin	☐ YES ☐ NO	Local anesthesia	☐ YES ☐ NO	Penicillin	☐ YES ☐ NO
Codeine	☐ YES ☐ NO	Latex	☐ YES ☐ NO	Other antibiotics	☐ YES ☐ NO

Please list any other drugs or materials you are allergic to: ______________________

1st UPDATE Any changes? ______________________ Date: ______________

______________________ ______________________ ______________________

Patient/guardian signature Reviewed by doctor Date