BLUEGRASS ENDODONTICS

Date: _____

Patient information

Patient Name: _____ DOB: _____ Patient SSN: _____

Patient Address: _____ Apt: _____ Zip Code: _____

Home phone: _____ Cell phone: _____

Employer: _____ Employer Phone Number: _____

Person Responsible (If different from patient): _____ SSN: _____ DOB: _____

Dentist: _____ Family Physician: _____

Emergency contact: _____ Phone number: _____ Relation: _____

Dental Insurance

Name of Policy Holder: _____ Employer: _____ Ins company: _____

Sub Date of Birth: _____ Sub SSN #: _____ Secondary Ins: _____

Health History

Have you or a family member been here before? _____ Name? _____
Chief Complaint for today's appointment: _____
Is the present problem due to an accident: _____ Last Physical: _____
Have there been any changes in your medical history or serious illness in the last year: _____
Allergy to any medications?: _____

Pharmacy Name: _____ **Pharmacy Location:** _____

Do you have (circle all that apply): Allergy, Anemia, Arthritis/rheumatism, Artificial joints, Asthma, Diabetes, Epilepsy, Fainting, Hay fever, Heart disease, Hepatitis, High blood pressure, Hives, HIV, Kidney disease, Liver disease, Low blood pressure, Mitral valve prolaps, Seizures, Stomach problems, Thyroid problems, Tuberculosis,
OTHER: _____ Pre-med for a condition: _____

Do you have a blood or clotting disorder?: _____
Are you taking any medication if so please list: _____
Women: Are you pregnant: _____ Nursing? _____
Have you ever had any complications associated with previous dental treatment if so explain:
_____

_____ **Please initial as acknowledgement: I understand that I need to follow up with my general dentist after the completion of my root canal for a permanent restoration.**

I hereby grant authority to Bluegrass Endodontics to perform treatment procedures, including the administration of anesthetics and medication, he/she deems necessary for the care of the patient named above. I have read and understand the patient information sheet provided.

_____ _____
Signature of Patient/Guardian Date

_____
Signature of Doctor