



CAPITAL ENDODONTICS

Health Information

Due to the sensitive information on this form, please do not return via email. Please complete in advance and bring it with you at the time of your appointment.

Patient Name _____ Date of Birth _____

Name of Referring Dentist _____

Are you currently taking any drugs and/or medications? Yes No
If yes, please list:

Are you under medical treatment now other than dental treatment? Yes No
If so, please explain

Have you ever been hospitalized, had a major operation or serious illnesses? Yes No
If so, please explain

Are you allergic to any of the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> Anesthetics | <input type="checkbox"/> Latex | <input type="checkbox"/> Fluoride |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Metals | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Bleach | <input type="checkbox"/> Other medications |
| <input type="checkbox"/> Rubbing alcohol | <input type="checkbox"/> Pain medications | |

Please include any items not specified above: _____

Do you presently have, or have you ever had any of the following? (Please check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Mental depression | <input type="checkbox"/> Artificial joints/prosthesis |
| <input type="checkbox"/> Heart ailment or disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Tumors or growths |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Drug abuse/addiction | <input type="checkbox"/> Radiation treatments |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> AIDS or HIV |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart valve implant | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Poor blood clotting | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Angina (chest pain) | <input type="checkbox"/> Alcohol abuse/addiction |

Continued on next page

<input type="checkbox"/> Asthma	<input type="checkbox"/> Blood disease	<input type="checkbox"/> STD/STI
<input type="checkbox"/> Intestinal disease	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Other _____
<input type="checkbox"/> Liver disease	<input type="checkbox"/> Respiratory disease	<input type="checkbox"/> Other _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Anorexia/bulimia	<input type="checkbox"/> Chemotherapy	
<input type="checkbox"/> Stomach disease	<input type="checkbox"/> Hepatitis	

Are you pregnant? Yes No
 If so, your expected due date is _____

I certify that the information that I have provided is complete and accurate. I understand that it is my responsibility to notify this dental office of any changes prior to initiating any dental treatment.

We will have you sign this form upon check in for your appointment.

Patient Signature _____ Date _____

Health Information Update

Date _____	No Updates _____	Updated _____
Date _____	No Updates _____	Updated _____
Date _____	No Updates _____	Updated _____
Date _____	No Updates _____	Updated _____
Date _____	No Updates _____	Updated _____
Date _____	No Updates _____	Updated _____
Date _____	No Updates _____	Updated _____