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?

___ Anesthetics
___ Penicillin
___ Codeine
___ Rubbing alcohol
___ Latex
___ Metals
___ Bleach
___ Pain medications
___ Fluoride
___ Iodine
___ Other 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)

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

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___ Asthma
___ Blood disease
___ Venereal disease
___ Intestinal disease
___ Hemophilia
___ Other _____
___ Liver disease
___ Respiratory disease
___ Other _____
___ Diabetes
___ Tuberculosis
___ Anorexia/bulimia
___ Chemotherapy
___ Stomach disease
___ 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.

Patient Signature _____ Date _____

Health Information Update

Date _____ No Updates _____ Updated _____

Date _____ No Updates _____ Updated _____

Date _____ No Updates _____ Updated _____

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