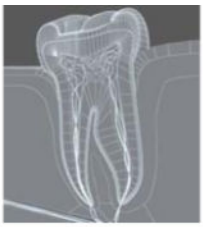


PRECISION ENDODONTICS, PC

Date: _____

Patient Information

Patient Name: _____ Email: _____
Last First MI (Preferred Name)

Single_____ Married_____ Other____ Gender: _____ **Birth Date**: _____

Social Security #:_____

Phone (Home): _____ (Work)_____ Cell: _____

Address: _____
Street City State Apartment # Zip Code

Health Information: Please List All That Apply

- Do you need to pre-medicate for any dental work? _____ Why? _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you ever had any type of major surgery in last 5 years?☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

Name of Physician: _____ Phone: _____

☐AIDS/ HIV
☐Alzheimer's Disease
☐Anemia
☐Arthritis/ Gout
☐Artificial Heart Valve
☐Artificial Joints
☐Asthma
☐Blood Disease
☐Blood Transfusion
☐Cancer
☐Chemotherapy
☐Cold Sores
☐Congenital Heart Lesion
☐Crohn's Disease
☐Diabetes
Last A1C? _____
☐Dizziness/Fainting
☐Drug Addiction
☐Eating Disorder
☐Epilepsy/Seizures
☐Excessive Bleeding
☐Glaucoma
☐Hay Fever
☐Head Injuries
☐Heart Disease
☐Heart Murmur
☐Hepatitis A/B
☐ Hepatitis C
☐Radiation Treatment
☐High Blood Pressure
☐Hypoglycemia
☐Irregular Heart Beat
☐Jaundice
☐Kidney Disease
☐Liver Disease
☐Lung Disease
☐Mental Disorder
☐Mitral Valve Prolapse
☐Nervous Disorder
☐Pacemaker
☐Pregnant Due: _____
☐Psychiatric Care
☐Respiratory Problems
☐Rheumatism
☐Sinus Problems
☐Stomach Problems
☐Stroke
☐Thyroid Disease
☐ Tobacco Use:
How much? _____
☐Tuberculosis
☐Ulcers
☐Venereal Disease

Allergies:

☐ Anesthetic
☐ Aspirin, Ibuprofen
☐ Codeine
☐ Iodine
☐Penicillins
☐ Sulfa Drugs
☐ Tylenol
☐Environmental
☐Latex
☐Foods: _____
☐ Other:_____

Medications: Please list **ALL** prescription and over the counter medications or attach list

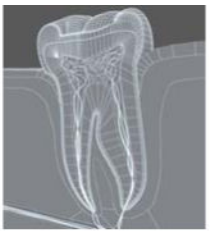
☐ _____
_____
_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Name of person or office referring you to our practice:



PRECISION ENDODONTICS, PC

Insured Person Information

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for the insured person:

1) Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ SS/ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance.

All emergency dental services, or any dental service preformed without previous financial arrangements, must be paid in full at the time services are performed.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian