Welcome to Advanced Endodontics

Patient Information

□Mr. □Mrs. □Ms. □Dr. First Name_____ MI___ Last Name_____Nickname_____

Date of Birth ____/_____/_____ Sex □ M □ F E-Mail_____

Address_____ City_____State_____ Zip_____

Phone _____ □Home □Mobile□Work Alternate Phone _____ □Home □Mobile □Work

General Dentist _____How did you hear about us? □ Your dentist □ Friend □ Insurance □ Internet □ Other

Other dental specialists you see (i.e., periodontist) _____

Physician _____ Phone _____

Person Responsible For Account (if other than patient)

First Name_____ MI___ Last Name_____ Tel_____

Relationship to patient: □Spouse □Father □Mother □Other

Address _____ City_____ State_____ Zip_____

Primary Insurance Info

Ins. Co._____ Employer_____

Employee: First_____ Last _____

Birth Date_____/_____/_____ SS#_____

Relation to patient: □Self □ Spouse □ Father □ Mother

Secondary Insurance Info

Ins. Co._____ Employer_____

Employee: First_____ Last_____

Birth Date_____/_____/_____ SS#_____

Relation to patient: □Self □ Spouse □ Father □ Mother

Emergency Contact

In case of emergency contact _____ □ Spouse □ Father □ Mother □ Other

Phones: Home _____ Business _____ Cell _____

Reason for Visit

What is the reason for your visit today?

_____

_____

_____

How long have you had this problem?

_____

What are your symptoms?

_____

_____

Medical History

Please answer the following questions to the best of your knowledge. Although endondontists primarily treat the mouth area, medical problems or medications could have a significant impact on your dental treatment. Your answers are confidential.

1.Are you under a physician's care now? □no □yes (if yes please give reason)_____

2.Have you had or presently have any of the following conditions? Check yes or no

Y N		Y N		Y N	
□ □	Heart valve replacement or vascular graft	□ □	Respiratory problems	□ □	Kidney trouble
□ □	Damaged heart valves/prosthetic valve	□ □	Tuberculosis	□ □	Are you on dialysis
□ □	Congenital heart disease	□ □	Emphysema	□ □	Arthritis/joint disease
□ □	Heart attack(s)/myocardial infarction (MI)	□ □	Parkinson's disease	□ □	Stomach ulcers/GERD
□ □	High blood pressure	□ □	Smoking/chewing tobacco	□ □	Irritable bowel syndrome
□ □	Low blood pressure	□ □	Blood transfusion	□ □	Delay in healing
□ □	Chest pain/angina	□ □	History of drug abuse	□ □	Bruise easily
□ □	Mitral valve prolapse/heart murmur	□ □	Eye disease/glaucoma	□ □	Anemia
□ □	Cardiac pacemaker	□ □	Abnormal bleeding	□ □	Immune system problems
□ □	Heart surgery/bypass surgery	□ □	Hepatitis/jaundice/liver disease	□ □	History of alcohol abuse
□ □	Stroke/Transient Ischemic Attack (TIA)	□ □	HIV/AIDS/STD	□ □	Tumor/ growth
□ □	Sinus infections	□ □	Infectious mononucleosis	□ □	Mental health problems
□ □	Convulsions/epilepsy	□ □	Fainting spells	□	Other _____
□ □	Bronchitis/chronic cough	□ □	Thyroid trouble		_____
□ □	Asthma	□ □	Diabetes		_____
□ □	COPD	□ □	Low blood sugar		

Y N

□ □ cancer (if yes please describe type, when treated etc)_____

□ □ implanted devices (if yes please describe type, when treated, etc)_____

Medications

1. Please list all medications that you are currently taking and the reason why

1._____ for _____ 6._____ for _____
2._____ for _____ 7._____ for _____
3._____ for _____ 8._____ for _____
4 _____ for _____ 9._____ for _____
5._____ for _____ 10._____ for _____

2. Are you taking Bisphosphonates (Fosamax, Acetonel, Aredia, Boniva, Zometa, Didronel)? □ no □ yes

3. Are you taking blood thinners (Coumadin (Warfarin), Plavix, Aspirin etc)? □ no □ yes

Allergies

4. Are you allergic to or had an unusual reaction to any of the following? (if yes please explain)

Y N		Y N		Y N		Y N	
□ □	latex	□ □	penicillin, Amoxicillin	□ □	motrin/anti-inflammatory	□ □	aspirin
□ □	narcotics	□ □	other antibiotics	□ □	dental local anesthetics	□ □	codeine

Other allergies/reactions (or explanation from above)_____

Women

1. Women: Are you pregnant? □ no □ yes If yes, estimated delivery date?_____

Are you nursing your child? □ no □ yes Are you taking birth control pills? □ no □ yes (Antibiotics, such as penicillin, may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control if antibiotics are prescribed.)

All Patients

□ yes □ no Have you been told by your physician to take antibiotics prior to dental treatment?
□ yes □ no Is there any health condition about which the doctor should know?
□ yes □ no Do you wish to speak to the doctor privately about anything?

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my endodontist, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form. I understand that I am responsible for notifying my endodontist of any medical changes upon each visit.

Patient Signature:_____ **Date:_____/_____/_____**
(Parent or Guardian if minor)

Authorization

I authorize my endodontist and his/her staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. If medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

Patient Signature:_____ **Date:_____/_____/_____**
(Parent or Guardian if minor)

Acknowledgement of Receipt of Notice of Privacy Practices

Dr Hirschman will only use and disclose your personal health information to treat you and to receive payment for the care we provide and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies about your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website, and have copies available for distribution. You may refuse to sign this acknowledgement.

Patient Signature:_____ **Date:_____/_____/_____**
(Parent or Guardian if minor)