PLEASE CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE OR HAVE HAD IN THE PAST:

Heart Trouble Heart Murmur Mitral Valve Prolapse

Rheumatic Fever Angina High Blood Pressure

Epilepsy Asthma Paget's Disease Low Blood Pressure

Stroke / TIA Multiple Myeloma Congenital Heart Disease

Diabetes Osteogenesis Imperfecta Thyroid Disease

Tuberculosis Arthritis Glaucoma Anemia

Lung Disease Radiation Treatment Convulsion

Herpes Hepatitis A B or C Kidney Disorder

Psychiatric Treatment Ulcer Migraine MS

Sinus Conditions Fainting Spells Venereal Disease

Osteoporosis Blood Disorders Other:_____

Cancer-Type:_____

PLEASE CIRCLE ANY OF THE FOLLOWING TO WHICH YOU ARE ALLERGIC OR HAVE HAD AN UNUSUAL REACTION TO:

Latex Epinephrine Novocaine / Xylocaine Barbiturates

Vancomycin Penicillin / Amoxicillin / Ampicillin / Augmentin

Clarithromycin (Biaxin) / Erythromycin / Azithromax, Azithromycin, Zithromax (Z-PAK)

Metronidazole (Flagyl) Moxifloxacin (Avelox)

Sulfa Drugs / Bactrim Clindamycin (Cleocin) / Lincomycin

Tetracycline / Doxycycline /Minocycline (Minocin)

Cephalexin (Keflex) / Cefaclor (Ceclor) / Cefuroxime (Ceftin)

Ciprofloxacin (Cipro) Valium Sedatives Steroids

Advil / Motrin / Ibuprofen Aleve / Naproxen Aspirin Codeine

Acetaminophen (Tylenol) Tramadol (Ultram) Vicodin

Other:_____

GENERAL HEALTH

Excellent Good Fair Poor

Are you under the care of a physician at this time?_____

If yes, explain:_____

Physician Name:_____

Do you have artificial joints? YES_____ NO_____

Have you been instructed to pre-medicate with large dose antibiotics one hour prior to your dental appointments? YES _____ NO_____ ** If Yes, did you take them?_____

LIST THE NAMES OF ALL

Prescribed and Non-Prescribed medications, vitamins, supplements, recreational drugs, etc. that you are taking today:

_____

_____

_____

_____

_____

Are you taking or have you taken **in the past 10 years** any **Bisphosphonates**? (EX: Actonel, Aldronate, Aredia, Boniva, Didronel, Fosamax, Reclast, Skellid, Zometa)

YES ____ NO____ If YES, which one?_____

Do you have a pacemaker or heart valve prosthesis?

YES_____ NO_____

Have you been hospitalized or had a serious illness in the past five years? YES_____ NO_____

If YES, Explain_____

Have you ever been diagnosed as having **HIV** or **AIDS**?

YES_____ NO_____

Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?

YES_____ NO_____

Are you pregnant? YES_____ NO_____ If YES, how far along are you? _____

Have you ever undergone endodontic treatment (Root canal therapy or apical surgery)? YES_____ NO_____

What symptoms are you experiencing today?

_____

_____

_____

_____

_____

Is there any other information we should know about your health or teeth?

_____

_____

_____

_____

_____

_____

SILVAGGIO ENDODONTICS
EASTON ENDODONTICS

PLEASE ANSWER **EACH AND EVERY QUESTION** ON **BOTH PAGES** OF THIS FORM. It is **IMPORTANT** to include all information we are requesting, especially MEDICATIONS, VITAMINS and SUPPLEMENTS you may be taking at this time.

Date:_____

Patient
Name:_____

Address:_____

City:_____ State:_____ ZIP:_____

Home Phone:_____

Work Phone:_____

Cell Phone:_____

Sex:_____ Marital Status:_____ Age:_____

Birth Date:_____ Soc Sec #_____

Occupation:_____

Employer:_____

Pharmacy:_____ Phone:_____
Pharmacy
Address:_____

Have you ever been treated by our doctors? Yes_____ No_____

Who **referred you to this practice**? Should they receive our report?
_____ Yes_____ No_____

Who is your **general dentist**? Should they receive our report?

_____ Yes_____ No_____

Are you seeing **any other dental professionals** to which you would like a report sent for this and/or any other visits?
Yes_____ No_____ If yes, who?_____

PLEASE READ THE FOLLOWING CAREFULLY:
The information contained on this form is correct, to the best of my knowledge. I agree to be responsible for all fees related to my visits here, including any returned check charges, as displayed. I allow release of all of my information to my dentist/doctors, as required by them.

To the extent permitted by law, I consent to your use and disclosure of my protested health information to carry out payment activities in connection with all insurance claims.

Signature:_____ Date:_____
(If the patient is a minor, parent/guardian must sign)

IF PATIENT IS A **MINOR UNDER 18 YEARS OF AGE**, PARENT/GUARDIAN MUST FILL IN THEIR

Name:_____

Soc. Sec. No.:_____ Birth Date:_____

Address / Phone, if different from Minor's:

_____

PLEASE FILL IN EACH SECTION WITH YOUR DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

DENTAL Insurance Co.:

_____

EMPLOYER the benefits are through:

_____

ID # / Soc. Sec. #:_____

IF THE PATIENT **IS NOT** THE SUBSCRIBER, PLEASE FILL IN:

Subscriber Name:_____

Relationship to the Patient:_____

Address if different from the Patient's:

_____

Subscriber ID #/ Soc. Sec. #:_____

Subscriber Date of Birth:_____

SECONDARY DENTAL INSURANCE

DENTAL Insurance Co.:

_____

EMPLOYER the benefits are through:

_____

ID #/ Soc. Sec. #: _____

IF THE PATIENT **IS NOT** THE SUBSCRIBER, PLEASE FILL IN:

Subscriber Name:_____

Relationship to the Patient:_____

Address if different from the Patient's:

_____

Subscriber ID #/ Soc. Sec. #:_____

Subscriber Date of Birth:_____