Practice Limited to Microscopic Endodontics & Apical Surgery

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Patient Information

Today's date ______________ Patient's First Name_____________________M.I.____Last Name_____________________

Sex: M☐ F☐ Date of Birth ____________ Age ____ Marital Status ______________ SS# _________________________

Address _____________________________________ City __________________________ State ______ Zip _____________

Phone Number (____)________________Work Number (____)_______________ Employer__________________________

Emergency Contact ____ Phone Number (_____)_______________________

Who is your general dentist? ________________________ ____________________________
First Name Last Name

IF MINOR, Responsible Party ________________________ ________________________ Relationship ________________
First Name Last Name

Date of Birth ______________ SS# ___________________________ Phone Number (_____)_______________________

Address _____________________________________ City __________________________ State ______ Zip _____________

Primary DENTAL Insurance Information

Insurance Company ___________________________________ ID# _________________ Group# ______________________

Policy Holder/Name of Insured __________________ ____________________ Relationship to patient _________________
First Name Last Name

Policy Holder Date of Birth _________________________________ Employer______________________________________

Insurance Co Address _______________________________ City _________________ State ________ Zip _____________

Insurance Co Phone Number (_________)____

Secondary DENTAL Insurance Information

Insurance Company ___________________________________ ID# _________________ Group# ______________________

Policy Holder/Name of Insured __________________ ____________________ Relationship to patient _________________
First Name Last Name

Policy Holder Date of Birth _________________________________ Employer______________________________________

Insurance Co Address _______________________________ City _________________ State ________ Zip _____________

Insurance Co Phone Number (_________)____

Please fill out the important medical history portion on the back of this sheet!

Patient Medical History

Name of Family Physician ________________ ________________ Address/City _________________________
First Name Last Name

Are you in overall good health? ☐**YES** ☐**NO** Do you consume alcohol? ☐**YES** ☐**NO** Do you use tobacco? ☐**YES** ☐**NO**

Do you currently have, or have you had, any of the following?

☐ Heart Disease	☐ Anemia	☐ Radiation Therapy	☐ Tuberculosis	☐ Emphysema
☐ High Blood Pressure	☐ Seizures	☐ Chemotherapy	☐ Liver Disease	☐ Hysterectomy
☐ Rheumatic Fever	☐ Fainting	☐ Thyroid Disease	☐ Bone Disease	☐ Psychiatric Therapy
☐ Heart Murmur	☐ Arthritis	☐ Sinus Trouble	☐ Lung Disease	☐ Bleeding Disorder
☐ Stroke	☐ Ulcers	☐ Tumor History	☐ Allergies	☐ Venereal Disease
☐ Diabetes	☐ Hepatitis	☐ Blood Disease	☐ Asthma	☐ AIDS/HIV

Are you taking any of the following?

☐ Echinacea	☐ Ephedra	☐ Feverfew	☐ Garlic	☐ Ginger	☐ Valerian
☐ Ginko	☐ Ginsing	☐ Kava	☐ Licorice	☐ St John's Wort	

Please list additional herbs or supplements: ____

☐ **YES** ☐ **NO**…………**Are you allergic to latex? If yes, STOP and notify receptionist right away!**

☐**YES** ☐ **NO**…………**Are you allergic or sensitive to any medication? Explain:**

☐**YES** ☐**NO**…………**Are you taking any medications or drugs? Please List**:

☐**YES** ☐ **NO**…………..Have you been hospitalized and/or had surgery **in the last 5 years**? Please List.

When ______________ Why ______________________________
When ______________ Why ______________________________
When ______________ Why ______________________________

☐**YES** ☐ **NO**……………Are you currently under the care of a physician? Explain:

____

☐**YES** ☐**NO**…………...Do you have any diseases or conditions not listed above? Please List:

____

WOMEN……………. …..Are you pregnant?☐**YES** ☐**NO** Delivery Date ___________Post-Menopause? ☐**YES** ☐**NO**

Dr. Acknowledgement ____
Kurosh Keikhanzadeh DDS, MDSc

Finances

Payment is expected on the date of service. For your convenience, we offer the following methods of payment. Please check the option you prefer. If you have any questions concerning our financial arrangements, it will be our pleasure to assist you.

☐ Cash/Check	☐ Visa	☐ Mastercard
☐ Discover	☐ AmEx	☐ Care Credit

Authorization, Release and Agreement

I consent to treatment as necessary or desirable for diagnosis of dental disease, deformity or treatment or dental emergency of the patient first named above. In case of a dental emergency, I consent to treatment as deemed necessary by the doctor, understanding the procedures will be explained in advance if possible. I understand it is solely my responsibility to report any changes in the above information to this office.

______________________________ ______________
Signature of Responsible Party Date