MILLENNIUM ENDODONTICS

HEALING WITH A GENTLE TOUCH

Patient Information

Patient Name: _____ Date: _____

Last First MI

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

Social Security #: _____ Date of Birth: _____

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

Address: _____

Street Apt #/Unit #

_____

City State Zip Code

Have you had or do you currently have any of the following:

☐ AIDS
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Blood Thinner
☐ Cancer
☐ Chemotherapy
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorder
☐ Nervous Disorder
☐ Pacemaker
☐ Phen Phen
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers

Allergies:
☐ Codeine
☐ Penicillin
☐ Other Allergies
Please List:
_____
_____
_____

Please list all medications you are currently taking: _____

_____

Are you pregnant? ☐ Yes ☐ No If yes, which trimester?: _____

Reason for this Visit: _____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever been admitted to a hospital or needed emergency care in the past 2 years? ☐ Yes ☐ No

If yes, please explain: _____

Are you under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

Name of physician: _____

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 Millennium Endodontics prior to my next appointment.

_____ _____

Signature of patient, parent or guardian Date

_____ _____

Signature of dentist Date