A Plus Endodontics

Fuwad Al-Sabek DMD, MS

PATIENT INFORMATION

❏ Mr. ❏ Mrs. ❏ Ms. ❏ Dr. First Name ________________________M.I. _____Last Name_________________________________

Sex: ❏ Male ❏ Female Birth Date _____________________Age __________Soc. Sec. # _________________________________

Street ____City_________________________ State _________Zip___________

Home Tel.________________ Cell._____________________Work ___________________Employer_________________________

Email ______________________________Emergency Contact __________________________Tel___________________

General Dentist _____________________________ Tel________________________________

How did you hear about us? ❏ Insurance Co. ❏ General Dentist ❏ Internet Search ❏ Online Yellow Pages ❏ Phone Book

❏ Former Patient (their name: ________________) ❏ Friend/Family (their name: ________________) ❏ Other ____________

Who will be responsible for your account? ❏ Self (If self, skip to next section) ❏ Spouse ❏ Parent ❏ Other __________________

First Name __________________________M.I. _____Last Name_________________________Soc. Sec. # __________________

Street ____City_________________________ State _________Zip___________

Home Tel.________________ Cell._____________________Work ___________________Employer_________________________

DENTAL INSURANCE INFORMATION

Primary Insurance Company __________________________ Tel. ____________________❏ DMO/HMO ❏ PPO ❏ DELTA CARE

Group # ____________________ Group Name ________________________Subscriber ID # _____________________________

(If other than patient) Insured Party's First Name ___________________Last Name_______________________Relation __________

Street ____City_________________________ State _________Zip___________

Birth Date _____________Soc. Sec. # __________________Tel. ____________________Employer_________________________

MEDICAL HISTORY **Have you had or do you currently have:**

Fibromyalgia	❏ Yes ❏ No	HIV	❏ Yes ❏ No	Cancer	❏ Yes ❏ No
Heart Murmur/Mitral Valve Prolapse	❏ Yes ❏ No	Angina/Heart Attack	❏ Yes ❏ No	Stroke	❏ Yes ❏ No
Heart Valve/Joint Replacement	❏ Yes ❏ No	Pacemaker	❏ Yes ❏ No	Epilepsy	❏ Yes ❏ No
Rheumatic Fever	❏ Yes ❏ No	High Blood Pressure	❏ Yes ❏ No	Pregnant, Nursing	❏ Yes ❏ No
Diabetes	❏ Yes ❏ No	Kidney Disease	❏ Yes ❏ No	Asthma	❏ Yes ❏ No
Hepatitis/Liver Disease	❏ Yes ❏ No	Thyroid Disease	❏ Yes ❏ No	Sinus Problems	❏ Yes ❏ No
Irritable Bowel / Ulcerative Colitis	❏ Yes ❏ No	Bruising/Bleeding Problems	❏ Yes ❏ No	Substance Abuse	❏ Yes ❏ No
Penicillin Allergy	❏ Yes ❏ No	Stomach Ulcers	❏ Yes ❏ No	Mental Health Prob	❏ Yes ❏ No
Latex Allergy	❏ Yes ❏ No	Tuberculosis/Lung Problem	❏ Yes ❏ No	Other Condition	❏ Yes ❏ No

Has your physician/cardiologist instructed you to premedicate with antibiotics prior to a dental appointment? ❏ Yes ❏ No

If Yes to any, please explain: ____

Medications presently taking (bone density medications, bisphosphonates, blood thinners, vitamins, supplements, others):

____

Allergic to any drugs or medications: ____

I certify that the above information is correct:

_________________________________ _________________

Patient Signature (or guardian of a minor) Date