HEALTH HISTORY AND PATIENT INFORMATION

(Please Print)

Married
Single
Widowed
Divorced

Gender ☐ M ☐ F

Last Name _____ First Name _____ Middle Initial _____

Address _____
Street _____ City _____ State _____ Zip _____

SSN _____ If patient is minor, responsible parent _____

Home/Cell # _____ Business Phone _____

Employed by _____ Occupation _____

Who Referred You? _____ Family Dentist (if different) _____

Family Physician _____ Date of Last Physical _____

Date of Birth _____ Age _____

PLEASE CHECK YES OR NO:

	YES	NO
1. High Blood Pressure	☐	☐
2. Low Blood Pressure	☐	☐
3. Asthma	☐	☐
4. Kidney Disease	☐	☐
5. Seizures	☐	☐
6. Stroke	☐	☐
7. Pacemaker	☐	☐
8. Heart Condition	☐	☐
If yes, please specify _____		
9. Endocarditis (inflamation or infection of the heart)	☐	☐
10. Episode of Prolonged Bleeding	☐	☐
11. Anemia	☐	☐
12. Diabetes	☐	☐
13. Thyroid Problems	☐	☐
14. Cancer	☐	☐
15. Arthritis	☐	☐
16. Hepatitis	☐	☐
17. AIDS/HIV	☐	☐
18. TB/PPD Positive	☐	☐
19. Cold Sores or Mouth Ulcers	☐	☐
20. GI/Intestinal Issues (i.e. Colitis or Clostridium Difficile)	☐	☐
21. Are you pregnant? what trimester _____	☐	☐

	YES	NO
22. Major Operation	☐	☐
List & Date _____		
23. Do you have a prosthetic device?	☐	☐
☐ heart valve ☐ hip ☐ knee		
☐ organ transplant ☐ other _____		
If so, what is the name of the Doctor who placed the prosthetic device?		
Name: _____		
24. Glaucoma	☐	☐
25. Do you take oral steroids?	☐	☐
26. Do you take blood thinners? (i.e. Coumadin / Plavix / Aspirin)	☐	☐
27. Do you take / have taken Oral or IV bone density medications (i.e. Fosamax / Boniva)?	☐	☐
28. **ALLERGY**		
Latex	☐	☐
Penicillin	☐	☐
Sulfa	☐	☐
Local Anesthetic	☐	☐
Pain Medication (i.e. Codeine)	☐	☐
Other Medication Allergies _____		
29. Does a physician require you to take antibiotics for premed before dental visits? (i.e. For heart condition, knee or hip replacement)	☐	☐

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Berks Endodontics
SCOTT BRAM, D.M.D. • BRIAN FREY, D.M.D.

Please list any medications used and their purpose:

Are you presently under a physician's care? . . . . . **YES** **NO**

For what specific condition?

Name of Physician

Date of Last Medical Exam

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Are you in discomfort now?

2. What causes the discomfort? (circle all that apply) **COLD** **HOT** **CHEWING** **CONSTANT**

3. How long have you had this discomfort?

4. Can you pinpoint the tooth causing the problem?

5. Have you noticed any swelling in the gums or a "bubble" by the tooth?

Do you have dental insurance? . . . . . **YES** **NO**

If yes . . . . Do you have more than one dental insurance? . . . . . **YES** **NO**

Insurance Company Name(s)

Insurance Company Address

Telephone #

Insured's Name Insured's DOB

Insured's Social Security #

Insured's Employer

Group # Insured's ID #

PLEASE READ THE STATEMENT BELOW AND SIGN IN THE SPACE PROVIDED.

PATIENT'S RESPONSIBILITY - I have completed this form and fully certify that all the above information is **true and correct**. I also certify that I am the **patient** (or authorized agent of the patient) **authorized** to furnish all information requested. I understand that even if I have some form of insurance coverage, that I am the person responsible for payment of services rendered. **I am aware that the dentist is a participating doctor with multiple insurance companies.**

Patient's Signature (or Parent if patient is a minor) Date