

SOUTHWEST MICHIGAN ENDODONTICS

3012 Niles Rd. St. Joseph  
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Date \_\_\_\_\_

Patients name \_\_\_\_\_ (M) (F) Birthday \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_  
Telephone # Res. \_\_\_\_\_ Work \_\_\_\_\_ Ext. \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Patient Soc. Security \_\_\_\_\_ General Dentist \_\_\_\_\_ City \_\_\_\_\_  
Primary Dental Ins. \_\_\_\_\_ Employer \_\_\_\_\_  
Subscriber \_\_\_\_\_ Birthday \_\_\_\_\_ Soc. Sec # \_\_\_\_\_  
Secondary Dental Ins. \_\_\_\_\_ Employer \_\_\_\_\_  
Subscriber \_\_\_\_\_ Birthday \_\_\_\_\_ Soc. Sec # \_\_\_\_\_  
Signature of responsibility for amount not paid by insurance \_\_\_\_\_

If patient is a minor:

Parent or Guardian name and address \_\_\_\_\_  
Soc. Sec. # \_\_\_\_\_ Employer \_\_\_\_\_ Phone \_\_\_\_\_  
Signature of person responsible for this account \_\_\_\_\_

Name of physician \_\_\_\_\_

Have you had a physical in the last two years?..... YES NO  
Are you under a physicians care currently?..... YES NO  
Have you been hospitalized within the last 5 years?..... YES NO  
Are you required to take Antibiotics before dental visits? ..... YES NO  
Are you taking Coumadin? ..... YES NO  
Are you subject to prolonged bleeding? ..... YES NO  
Have you ever taken the appetite suppressant Fen Fen? ..... YES NO  
Have you taken cortisone or steroids in the last 12 months?..... YES NO

Women only:

Are you taking birth control pills?..... YES NO  
Are you pregnant and if so what month?..... YES NO

Circle any of the following to which you are allergic, or have caused an unusual reaction:

Penicillin                      Aspirin                      Cleocin  
Latex                              Codeine                      Erythromycin  
Local anesthetic              Valium                      Nitrous Oxide  
Novocaine                      Keflex                      Other \_\_\_\_\_

Do you have or have you had any of the following? Please circle:

Heart Trouble              Blood Disorder              Kidney Trouble              Hepatitis  
Heart Attack              Diabetes                      Radiation Therapy              Thyroid Disorder  
Heart Murmur              Epilepsy                      Arthritis                      Psychiatric Treatment  
Rheumatic Fever              Glaucoma                      Venereal Disease              Herpes  
Artificial Joint              Tuberculosis              HIV/Aids                      Mitral Valve Prolapse  
Stroke                      Asthma                      Liver Disease                      Respiratory Disease  
Stomach problem (Ulcer)              High Blood Pressure              Other \_\_\_\_\_

List any medications you are presently taking \_\_\_\_\_  
\_\_\_\_\_

