CONFIDENTIAL HEALTH HISTORY

Patient Name_____ Date of Birth_____ Sex: M F

Who referred you to our office?_____ Phone _____

Who is your Dentist?_____ City _____

Who is your Physician (Medical Doctor)?_____ City _____

1. Do you presently have a toothache? Yes ___ No ___
2. Have you had a previous Endodontic (Root Canal) Treatment? Yes ___ No ___
3. Are you in good health?_____
4. Are you currently under the care of a physician? Yes ___ No ___

   If yes, please explain_____
5. If female, are you pregnant? Yes ___ No ___ What month? _____

   Do you anticipate becoming pregnant? Yes___No ___ Are you nursing? Yes ___ No ___
6. Have you ever had trouble with prolonged bleeding? Yes ___ No ___
7. Have you ever had an unusual or allergic reaction to a drug/medicine or material such as Penicillin, Erythromycin, Aspirin, Codeine, Novocaine, Latex, etc.?_____
8. Please list all medicines you are presently taking_____

   _____
9. Is there any other information that we should know about your health?_____

   _____

   About previous dental visits?_____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT:

Heart Attack	Anemia	Diabetes	Epilepsy or Seizures
Heart Condition	Hemophilia	Glaucoma	Fainting or Dizzy Spells
Heart Murmur	Bleeding Disorders	Kidney Trouble	Nervous Disorders
Chest Pains (Angina)	Stroke	Liver Disease	Thyroid Disease
Heart Surgery	Bruise Easily	Hepatitis A (infectious)	Cancer or Other Tumor
Artificial Heart Valve	Blood Transfusion	Hepatitis B (serum)	Radiation Therapy
Heart Pacemaker	Lung Disease	Yellow Jaundice	Chemotherapy
High Blood Pressure	Shortness of Breath	Alcoholism	Cold Sores
Swelling of Ankles	Asthma or Hay Fever	Drug Addiction	Herpes
Rheumatic Fever	Tuberculosis (TB)	Arthritis or Rheumatism	Venereal Disease
Cortisone Medicine	Emphysema	Pain in Jaw Joints (TMJ)	AIDS (HIV +)

To the best of my knowledge, the above information is complete and accurate. If there is a change in my health or medicines, I will inform the doctor at the next appiontment.

_____

Signature of: Patient Parent Guardian (circle one) Date

Medical Condition Update

_____

_____

_____

Please turn over and complete back side

PATIENT INFORMATION

Patient Name _____

Social Security Number _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Marital Status (circle) married single widowed divorced

Employer _____ Job Title _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Spouse's information (*Parent's or Guardian's if patient is a minor*) Name _____

Social Security Number _____ Date of Birth _____

Employer _____ Job Title _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Person Responsible for Account (if other than patient) _____

Social Security Number _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Relation to Patient _____

Employer _____ Job Title _____ Work Phone _____

In Case of Emergency, Nearest Relative Not Living With You _____ Phone _____

FINANCIAL RESPONSIBILITY AGREEMENT

In consideration of treatment rendered to the above named patient, I accept full financial responsibility. Insurance forms will be completed as a convenience to the patient, however, payment to the doctor is expected at the time services are rendered, unless other arrangements are made in advance. I further agree that if this account is turned over to an attorney or collection agency, I will be responsible for all collection costs, interest of 21% APR, court costs and reasonable attorney fees.

X _____

Signature Relation to Patient if Minor Date

INSURANCE INFORMATION

(Please present your insurance card to the receptionist)

Dental Insurance Company _____ Phone _____

Address _____ City _____ State _____ Zip _____

Name of Insured _____ Group/Plan I.D. Number _____

Secondary Dental Insurance _____

If you wish for our office to process your insurance claim for you, please sign the insurance authorizations below:

Authorization to Release Information: Meridian Endodontics is authorized to provide any insurance company(s) claim administrators(s) and consulting health care professionals, information concerning health care, advice, treatment, or supplies provided.

Authorization to Pay Benefits Directly to Dentist: I hereby authorize payment directly to meridian endodontics , of the dental benefits otherwise payable to me.

X _____ X _____

Signature (Patient or Authorized Person) Date Signature (Insured Person) Date