Kenneth E. Endicott, D.D.S., M.S. & Associates

Medical History Questionnaire

Name________________________ Nickname________________________
Birthdate______________ Age_____ SS#______________________ Male__________ Female________
Home Address ______________________________ City____________ State___ Zip Code__________
Home#______________________ Cell/Other#____________________ Work#____________________
Where and when are the best times to reach you? ____________________________________
Single___ Married___ Divorced ___ Separated___ Widowed___ DL#__________________________
Who may we thank for referring you? __________________ Other family members seen by us____________

Spouse's Name________________ Spouse's Employer___________ Work#________ Spouse's SS#________
Birthdate____________ DL#______________

Employer ______________________________ Employer Address ________________________________
How long there?__________ Occupation____

Person Responsible for Account ______________________________________ Relationship___________
Home#______________________________________ Work #__________________________________
Billing Address____
SS#_______________ Employer________________________ DL#______________

Primary Dental Insurance
Insurance Co. Name____
Insurance Co. Address ____
Insurance Co. Phone#______________________ Group#(Local or Policy#)______________________
Insured's Name_____________________________________ Relation___________ Birthdate__________
Insured's SS#_________________________ Insured's Employer _______________________________

Secondary Dental Insurance
Insurance Co. Name____
Insurance Co. Address ____
Insurance Co. Phone#______________________ Group#(Local or Policy#)______________________
Insured's Name___________________________ Relation___________________ Birthdate__________
Insured's SS#_________________________ Insured's Employer _______________________________

In the unlikely event of an emergency is there someone who lives near you that we should contact?
Name ______________________________ Relation _________ Home#__________ Other# __________

Do you have a personal physician? Yes No
Physician's Name ___________________________________ Date of last visit____________________
Phone #____________________
Current physical health is: Good__ Fair__ Poor__ currently under the care of physician? Yes__No__
If "yes" please explain ____
Are you taking any prescription/over-the-counter medications? Please List *ALL* ______________
____
FOR WOMEN: are you pregnant? No__ Yes__ Week#_____ are you nursing? No__ Yes__

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Have you EVER had the following...

Heart Attack/Heart Disease	Y	N	Cancer	Y	N
Heart Murmur/Mitral Valve Prolapse	Y	N	Chemotherapy/Radiation Treatment	Y	N
Heart Surgery/Artificial Valves/Pacemaker	Y	N	Kidney Problems/Anemia	Y	N
Rheumatic Fever/ Rheumatic Heart Disease	Y	N	Stroke/Arthritis/Breathing Difficulty/ Asthma/Emphysema	Y	N
High/Low Blood Pressure	Y	N	Diabetes/Tuberculosis(TB)/Glaucoma	Y	N
Congenital Heart Defect	Y	N	Thyroid/Lung/Liver Disease	Y	N
Artificial Bones/Joints	Y	N	Drug/Alcohol Abuse	Y	N
Hospitalized for ANY reason	Y	N	Psychiatric Problems/ Nervousness/Depression	Y	N
Bleeding Tendencies/Blood Disorders	Y	N	Confusion/Memory Problems	Y	N
Blood Transfusion	Y	N	Tobacco Use (Cigarettes/Chewing etc.)	Y	N
Fever Blisters/Cold Sores	Y	N	Severe/Frequent Headaches	Y	N
Hepatitis (any type)	Y	N	Epilepsy/Seizures/Fainting Spells	Y	N
Venereal Disease	Y	N	Ulcers/Colitis	Y	N
HIV+/AIDS	Y	N	Have you ever been told you need an antibiotic premed?	Y	N

Please list any other serious condition you have/had____

Are you allergic to any of the following drugs?

Penicillin	Y	N	Tetracycline	Y	N	Latex	Y	N
Aspirin	Y	N	Dental Anesthetics	Y	N	Other	Y	N
Erythromycin	Y	N	Codeine	Y	N			

Please list any other drugs that you are allergic to____

Dental History

Why have you come to the dentist today?____

Have you ever had a serious problem associated with any previous dental treatment?_________________

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?________________

Have you ever had a traumatic experience at a dental office?____

Your current dental health is: Good_____ Fair_____ Poor_____ Do you like your smile? Yes_____ No_____

Do your gums ever bleed? Yes_____ No_____ How many times a week do you floss?_____

How many times a day do you brush?_____ Type of bristles: Hard _____ Medium_____ Soft_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the staff to perform, with my informed consent, any necessary dental services I may need during diagnosis and treatment. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance companies' arbitrary determination of usual and customary rates. In the event that my payments are not received within 90days of their due date, I agree to pay all costs of collections, including, but not limited to, reasonable attorneys fees. Payment is due in full at the time of treatment unless prior arrangements have been made. Thank You for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

Signature____Date____________________

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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