

Referring Dr. \_\_\_\_\_  
(Administrative use only)

### PATIENT INFORMATION

Name \_\_\_\_\_  
Last First Middle Initial

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Sec # \_\_\_\_\_

If patient is a minor, give parent's or guardian's name \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

### Responsible Party Information

Name \_\_\_\_\_  
Last First Middle Initial Marital Status

Residence \_\_\_\_\_  
Street City State Zip

Mailing Address \_\_\_\_\_  
Street City State Zip

How long at this address? \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Social Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

### (Primary or Secondary Insurance Holders Information)

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Last First M.I.

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Social Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

### Insurance Information

Primary Insurance \_\_\_\_\_ Secondary Insurance \_\_\_\_\_

Name of Company \_\_\_\_\_ Name of Company \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Group Num. \_\_\_\_\_ Local # \_\_\_\_\_ Group Num. \_\_\_\_\_ Local # \_\_\_\_\_

*INSURANCE: To avoid misunderstanding regarding dental insurance, we wish to emphasize that as Dental Care Providers, our relationship is with you, not your insurance company. All charges are your responsibility from the date the services are rendered. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies. Dental insurance, by design, is usually meant to be an aid rather than pay-all. Unlike major medical insurance, the amount (co-payment) or remaining balance, less what the insurance company pays, is typically higher. We do not believe that it is in your best interest to base your treatment on the limitations of your particular insurance program.*

### Emergency Contact Information

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Last First M.I.

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other \_\_\_\_\_

## Health History

These questions are *confidential* and help us provide better care.

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Are you in good health?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you seen a physician in the last 2 years?.....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have any allergies?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If yes, please list</i> _____  |                          |                          |
| 4. Have you had an unfavorable reaction to dental treatment?.....         | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If yes, please specify</i> _____                                       |                          |                          |
| 5. Have you ever had excessive bleeding requiring special treatment?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any other serious illness?.....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>If yes, please list</i> _____  |                          |                          |
| 7. If female, are you or might you be pregnant? Which month?.....         | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you nursing?.....   |                          |                          |
| <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you in a high risk group for infectious diseases?.....             | <input type="checkbox"/> | <input type="checkbox"/> |

9. Please indicate any of the following illnesses you have had:
- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Hay Fever                | <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Head Injuries |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Heart Condition/Disease  | <input type="checkbox"/> Penicillin Allergy   | <input type="checkbox"/> Tumors        |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Stroke        |
| <input type="checkbox"/> Blood Condition/Disease | <input type="checkbox"/> Hepatitis (Type _____)   | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Liver         |
| <input type="checkbox"/> Cancer (Type _____)     | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> Tuberculosis  |
| <input type="checkbox"/> Codeine Allergy         | <input type="checkbox"/> Sinus Problems           | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> HIV           |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Jaundice                 | <input type="checkbox"/> Stomach Problems     | <input type="checkbox"/> Epilepsy      |
| <input type="checkbox"/> Dizziness               | <input type="checkbox"/> Kidney Condition/Disease | <input type="checkbox"/> Drug History         | <input type="checkbox"/> Fainting      |
| <input type="checkbox"/> Mental Disorders        | <input type="checkbox"/> Low Blood Pressure       | <input type="checkbox"/> Ulcers or Colitis    | <input type="checkbox"/> Growths       |
| <input type="checkbox"/> Major surgeries _____   |   |   |  |
| <input type="checkbox"/> Other _____             |   |   |  |

11. Are you taking any of the following?
- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Meds for High Blood Pressure         | <input type="checkbox"/> Anitbiotics/Sulfa Drugs        | <input type="checkbox"/> Anitcoagulants(Thinners)     |
| <input type="checkbox"/> Insulin, Tolbutamide or similar drug | <input type="checkbox"/> Cortisone(Steroids)            | <input type="checkbox"/> Tranquilizers                |
| <input type="checkbox"/> Nitroglycerin                        | <input type="checkbox"/> Aspirin                        | <input type="checkbox"/> Digitalis or drugs for heart |
|   | <input type="checkbox"/> Bisphosphonates (like Fosamax) |   |
- Please list all other medications that you take: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

12. Name of your general physician \_\_\_\_\_

Date

Asst. Int. for Med Hx Review

Doctor's Signature

***The information provided is correct to the best of my knowledge. This includes any medical history and insurance information. I understand it is my responsibility to inform this office of any change in my medical and insurance history status.***

- In order to process your insurance claims, we will need your signature to release payment.
- I authorize release of any information relating to any claim for services rendered to me or my dependents.
- I assign and request your company to pay directly to the doctors of Oregon Endodontic Group insurance benefits otherwise payable to me or my dependents.
- I understand I am financially responsible to Oregon Endodontic Group for charges not covered by this assignment.
- A delinquent account may be referred to a collection agency.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

(If minor, parent's or guardian's signature)

**TELL US ABOUT YOUR SYMPTOMS**

Date \_\_\_\_\_

- 1. Are you experiencing any pain at this time? If not, please go to question 6. Yes  No
- 2. If yes, can you locate the tooth that is causing the pain? Yes  No
- 3. When did you first notice the symptoms? \_\_\_\_\_
- 4. Did your symptoms occur suddenly, or gradually? \_\_\_\_\_

5. ***Please check the frequency and quality of the discomfort, and the number that most closely reflects the intensity of your pain:***

**LEVEL OF INTENSITY**

(on a scale of 1 to 10)

1=mild 10=severe

1 \_ 2 \_ 3 \_ 4 \_ 5 \_ 6 \_ 7 \_ 8 \_ 9 \_ 10 \_

**FREQUENCY**

- Constant
- Intermittent
- Momentary
- Occasional

**QUALITY**

- Sharp
- Dull
- Throbbing

*Is there anything you can do to relieve the pain?*

*If yes, what?* \_\_\_\_\_

Yes  No

*Is there anything you can do to cause the pain to increase?*

*If yes, what?* \_\_\_\_\_

Yes  No

*When eating or drinking, is your tooth sensitive to:*

Heat

Cold  Sweets

*Does your tooth hurt when you bite down, or chew?*

Yes  No

*Does it hurt if you press the gum tissue around the tooth?*

Yes  No

*Does a change in posture cause your tooth to hurt?*

Yes  No

*(lying down or bending over)*

- 6. Do you grind, or clench your teeth? Yes  No
- 7. If yes, do you wear a night guard? Yes  No
- 8. Has a restoration (filling or crown) been placed on this tooth recently? Yes  No
- 9. Prior to today, has root canal therapy been started on this tooth? Yes  No
- 10. Is there anything else we should know about your teeth, gums or sinuses that would assist us in our diagnosis? Please explain: \_\_\_\_\_

\_\_\_\_\_

Assistant Notes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_