Name_____(Preferred Name)_____ Age _____ Height _____ Weight _____

Are you in good health? …….. Yes No
Are you able to walk up a flight of stairs without rest?…… Yes No
Are you anxious about dental treatment?……. Yes No
Do you wish to speak with the dentist privately about anything?…… Yes No
Are you wearing removable dental appliances?…….. Yes No
Are you wearing contact lenses?…….. Yes No
Do you currently use or have you previously used tobacco products?…… Yes No

If yes, what type? _____ How often? _____ When did you quit? _____

If you have had any serious trouble associated with previous dental treatment, please explain:_____
If you are currently being treated for any medical condition, please explain: _____
If you have had any serious illness, operation or hospitalization within the past 5 years, please explain: _____
_____
When was your last physical examination?_____ Physician's name and phone number _____
Reason for last visit _____

Do you currently have or have you had any of the following? Please circle yes or no. If yes, please specify.

YES NO Heart murmur requiring prophylactic antibiotic coverage before dental treatment
YES NO Damaged heart valves or artificial heart valves
YES NO Rheumatic heart disease requiring prophylactic antibiotic coverage before dental treatment
YES NO Heart trouble, angina, arteriosclerosis, pacemaker, mitral valve prolapse,
YES NO Abnormal rhythm, peripheral vascular disease, congestive heart failure
YES NO Congenital heart lesions, cardiac stent, chest pain
YES NO □ MI (heart attack) _____ □ TIA (stroke)_____
Date Date
YES NO Joint replacement, implant
YES NO Muscle weakness, paralysis, numbness, tingling
YES NO Hypertension (high blood pressure)
YES NO Osteoporosis, Paget's Disease, or other bone disease
YES NO Diabetes □ Type I □ Type II
YES NO Kidney disorder. Please specify: _____
YES NO Hepatitis, liver disease, jaundice
YES NO Anemia , bleeding, disorder, blood clots, transfusions, bleeding difficulty
YES NO Leukemia
YES NO Tuberculosis, persistent cough or coughing with blood
YES NO Any disease, drug or transplant that suppresses your immune system
YES NO Asthma
How often to you require your inhaler? _____ Is it with you? _____
Have you ever had an asthma attack in a dental office? _____

YES NO Joint problems, including jaw joint and arthritis
YES NO Migraine headaches
YES NO Visual problem or glaucoma
YES NO Digestive problem, ulcers or ulcerative colitis
YES NO Hiatal hernia, gastric reflux
YES NO Recent cold, pneumonia, cough, flu, easily winded
YES NO Cold sores
YES NO Hay fever, seasonal allergies
YES NO Fainting or dizziness
YES NO Epilepsy or seizure disorder
YES NO Cancer Type & Location_____
Date Treated:_____□ Metastic □ Malignant
YES NO Chemotherapy or radiation
YES NO Neurological disorder
YES NO Psychiatric treatment and/or medications
YES NO Alcohol/addiction problems
YES NO □ AIDS □ HIV □ STD
YES NO Infectious disease
YES NO Tumor or growths
YES NO Respiratory problems: emphysema, bronchitis, etc.
YES NO Thyroid problems □ Hypo □ Hyper
Please specify medication: _____

YES NO Recent □ weight loss or □ weight gain
YES NO Are you now using or have you ever used illegal drugs (cocaine, heroin, methamphetamine)? Chronic marijuana use? □ Yes □ No
YES NO Do you currently take or have you previously taken bisphosphonates? ie. Actonel, Aredia, Boniva, Bonefos, Fosamax, Ostac, Skelid, Zometa, etc.
YES NO Have you ever taken medication for osteoporosis or osteopenia? i.e. Prolia, Reclast, Miacalcin, Fortical, Calcimar, Forteo, Loron, Didronel, etc.

Have you ever had any ALLERGIC or adverse reaction to any of the following? *Please specify reaction.*

□ Penicillin □ Barbiturates or sleeping pills □ Latex □ Table Salt
□ Antibiotic □ Aspirin □ Iodine
□ Sulfa drugs □ Tylenol □ Household bleach
□ Codeine or other narcotic □ Local anesthetic □ Other _____

Are you taking any medications, including non-prescription, homeopathic or "natural" remedies, & diet pills? *Please specify name & dosage*

□ Antibiotic _____ □ Pain medication _____
□ Heart medicine _____ □ Aspirin _____
□ Blood thinner _____ □ Cortisone/steroids _____
□ Blood pressure medicine _____ □ Other _____

Women Only: Are you pregnant or nursing? □ Yes □ No □ Possibly
Do you use birth control pills? □ Yes □ No

DENTAL HISTORY

Briefly explain why you were referred to this office, i.e., what symptoms have you had, if any?_____
_____
Are you currently having symptoms? □ Yes □ No When did the symptoms begin? _____
Can you point to the affected area? □ Yes □ No Have your symptoms □ worsened or □ gotten better?

Tooth location:	□ Upper Right	□ Lower Right	□ Upper Left	□ Lower Left	□ Upper front	□ Lower front
Has the pain been?	□ Constant	□ Intermittent	□ Momentary	□ Lingering	□ Referred	
Is the pain?	□ Sharp	□ Dull	□ Throbbing	□ Steady	□ Enlarging	□ Spontaneous
What affects the pain?	□ Hot	□ Cold	□ Sweets	□ Biting		
	□ Chewing	□ Tapping	□ Touch	□ Head position		

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature of patient or signature of legal guardian if patient is a minor. **Date**

ADVANCED ENDODONTICS OF GREATER SPRINGFIELD

Name_____ Preferred Name _____
Last *First* *Middle*

Address _____

City _____State _____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email address _____

At which may we contact you? □ Home □ Work □ Cell (Text OK? □ Yes □ No)

At which may we leave a message? □ Home □ Work □ Cell □ email

□ Male □ Female SSN _____-_____-_____ Date of Birth ____/_____/_____

Patient's Employer _____ Occupation _____

Spouse's Name _____ SSN _____-____-_____ DOB____/____/____

Spouse's Employer _____ Spouse's Work Phone _____

Please complete the following if patient is a minor.

Father's Name _____ SSN _____-____-_____ DOB____/____/____

Father's Mailing Address _____

Father's Employer _____ Father's Work Phone _____

Mother's Name _____ SSN _____-____-_____ DOB____/____/____

Mother's Mailing Address _____

Mother's Employer _____ Mother's Work Phone _____

Insurance Company Name _____

Group Number _____ Individual Policy Number _____

Insured Name _____

Patient's relationship to insured: □ Self □ Spouse □ Covered Dependent

Name of person to contact in case of emergency _____Phone _____

Patient's relationship to emergency contact: □ Spouse □ Parent □ Relative □ Friend □ Co-worker

Who may we thank for referring you to our office? _____

Who is your current general dentist? _____

By signing, you certify that you have received and read a copy of this office's Notice of Privacy Practices and that you have completed the above information to the best of your knowledge. By signing, you also authorize consent for Dr. Castleman and any other agents or employees of Advanced Endodontics to perform radiographic imaging, testing, and evaluation. By signing, you consent to the use and disclosure of protected health information as needed to carry out treatment. Your signature also authorizes this office to file insurance claims on your behalf. Please understand that you are responsible for payment of services regardless of insurance coverage and that interest will accrue if account balance is not paid in full within 60 days of treatment. After 60 days with no payment, please understand the account will be turned over to a collection agency and at that time you will then be responsible for the collection agency fees, as well as ours.

_____ _____

Signature of patient or signature of legal guardian if patient is a minor. **Date**