

Heartland Endodontic Specialists, L.L.C.

Michael S. Hermsen, D.D.S.
Christopher J. Redd, D.D.S.
Mary T. Goodman D.D.S., M.S.

Health History

Welcome to our office. Your time and feelings are most important to us. Therefore, we ask the following questions to help us best serve your needs. This information is, of course, confidential.

Patient's Name _____ Date of Birth _____ - _____ - _____

Street Address _____ City/State/Zip _____

Home Phone# _____ Cell Phone # _____

Work Phone# _____ Any other contact #s _____

Do you have dental insurance? Yes No ** If yes please continue: Are you the Policy Holder? Yes No

Please complete the following information required for claims: Insurance company _____

Employer insurance is through: _____ Insurance ID# or Social Security _____

Group # _____ Policy Holder's name: _____ Date of Birth _____

Relationship: _____

Is there Secondary Insurance? Yes No Insurance Company: _____

Secondary Policy Holders Name: _____ Employer: _____

Relationship _____ Date of Birth _____ - _____ - _____ ID # /SS# _____

Address if different from patient: _____ Phone: _____

1. My Referring dentist _____, physician's name _____

Are you under the care of a physician? Yes ____ No ____

If yes, what is the condition being treated? _____

2. Have you been hospitalized or had a serious illness or operation in the past five (5) years? Yes No

If yes, please explain _____

3. Do you have a joint replacement or heart condition requiring a pre-med prior to a dental procedure? _____

4. Do you have or have you ever had any of the following diseases or problems? Please check all that apply.

__ Damaged heart valves, __ artificial heart valves, __ heart murmur

__ Cardiovascular disease: __ heart attack, __ coronary occlusion, __ high blood pressure, __ stroke

__ Cardiac pacemaker

__ Allergy, __ sinus trouble, __ asthma, or __ hay fever

__ Hives or skin rash

__ Fainting spells or seizures (epilepsy)

__ Diabetes

- ☐ Hepatitis type ____, __jaundice or __ liver disease
☐ Arthritis
☐ Inflammatory rheumatism
☐ Stomach ulcers (current problem)
☐ Kidney trouble
☐ Tuberculosis
☐ Persistent cough
☐ Low blood pressure
☐ Venereal disease
☐ Psychiatric condition
☐ Cancer
☐ AIDS or other immunosuppressive disorder
☐ Rheumatic fever
☐ Anemia or other blood disorder
☐ Any other condition you have experienced that we should know about _____
4. Are you currently taking or recently completed any of the following? Please mark all that apply.
- ☐ Antibiotics or sulfa drugs. If yes, what are you taking? _____
☐ Medicine for high blood pressure. If yes, which one _____
☐ Anticoagulants (blood thinners)
☐ Tranquilizers
☐ Aspirin, Advil, Motrin, Tylenol
☐ Antihistamines
☐ Insulin, Tolbutamide (Orinase) or similar drug
☐ Digitalis, Nitroglycerin or any other drug for a heart condition
☐ Oral contraceptives or other hormonal therapy
☐ M.A.O. inhibitors (Your Doctor would tell you if you are)
☐ Bone preservation medication (Fosomax; Boniva; etc.) How long? _____
☐ Any other medication. If so what _____
5. If you are allergic or have reacted adversely to any of the following, please mark all that apply.
- ☐ Local anesthetics (Novocaine). If yes, please explain _____
☐ Epinephrine
☐ Penicillin or other antibiotic. If yes, which one _____
☐ Sulfa drugs
☐ Barbiturates, sedatives or sleeping pills. If yes, which one _____
☐ Aspirin, Advil or Motrin
☐ Codeine or other narcotic analgesics. If yes, which _____
☐ Latex
☐ Any other medication you have taken. If yes, which _____
6. Have you had abnormal or prolonged bleeding associated with any previous dental procedures? Yes No
7. Have you had surgery, radiation or drug treatment for any condition involving your head or neck? Yes No
8. Have you had any significant problem with any previous dental procedure? Yes No
- If yes, please explain _____
9. Do you have any disease, condition, or health problem not listed above? Yes No
- If yes, please explain _____

For Women only:

10. Are you or could you be pregnant? Yes No

I certify that I have read and understand the above health history. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Goodman, Dr. Hermesen, Dr. Redd or any of their staff responsible for any errors or omissions that I may have made in the completion of this form. I also give Heartland Endodontic Specialists authorization to file for insurance payment to my provider of services.

Patient Signature

Date