Heartland Endodontic Specialists, L.L.C.

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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

Please complete the following information required for dental claims:

1) Primary Dental Insurance company: _____Member ID: _____

Subscriber's Name: _____ Subscriber Employer: _____

Subscriber's DOB: _____ Group #: _____

Subscriber's SSN: _____ Relationship: _____

2) Is there Secondary Dental Insurance? Yes or No

Secondary Insurance Company: _____

Secondary Subscriber's Name: _____

Secondary Subscriber's DOB: _____ Employer: _____

Member ID: _____ Relationship _____ SSN: _____

Address if different from patient: _____Phone: _____

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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. Have you had abnormal or prolonged bleeding associated with any previous dental procedures? Yes No

5. Have you had surgery, radiation or drug treatment for any condition involving your head or neck? Yes No

6. Have you had any significant problem with any previous dental procedure? Yes No

   If yes, please explain _____

(over)

8. Do you have or have you ever had any of the following health conditions? 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
__ Currently or possibly pregnant. If yes, estimated due date: _____

9. Do you have any disease, condition, or health problems not listed above? Yes No
If yes, please explain _____

10. Are you currently taking or recently completed any of the following medications? 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 have informed you)
__ Bone preservation medication (Fosamax; Boniva; etc.) How long? _____
__ Any other medication. If so what _____

11. 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 another 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 _____

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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. Hermsen, 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/Guardian Signature Date