Heartland Endodontic Specialists, L.L.C.

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Practice Limited to Endodontics

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 a Secondary Insurance? Yes No

Secondary Policy Holders Name: _____ Employer: _____

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

Address if different from patient: _____Phone:_____

Please give us Authorization to file for Insurance payment to provider_____

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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. 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

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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. Ellison, 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.

_____ _____

Patient Signature Date