FORT WAYNE
ENDODONTICS, P.C.
Jason P. Glassley D.D.S.,M.S.D.
Adam R. Everhart D.D.S.,M.S.D.

NAME:_____
First Last

Allergies *Circle all that apply*
penicillin latex local anesthetic aspirin valium sulfa
ibuprofen codeine clindamycin Other: _____

Women Taking birth control pills? ❑ yes ❑ no Are you nursing? ❑ yes ❑ no Are you pregnant? ❑ yes ❑ no
If yes, which trimester _____

MEDICAL HISTORY

Cardiovascular (heart)	**Yes**
High Blood Pressure	____
Heart Attack	____
If so, when?_____	
Angina/Chest Pain	____
If so, when? _____	
Take Daily Aspirin	____
Coumadin/Blood Thinners	____
Heart Murmur	____
Mitral Valve Prolapse	____
Rheumatic Fever	____
Congenital Heart Defect	____
Prosthetic Heart Valve	____
Heart Pacemaker	____
Heart Surgery	____
If so, when?_____	
Other Heart Problems	____
If yes please describe:	
_____	

Nerves & Sensory	**Yes**
Severe Headaches	____
Fainting/Dizzy Spells	____
Epilepsy/Seizures	____
Trigeminal Neuralgia	____
Other: _____	
Respiratory	
Sinus Problems	____
Allergies or Hives	____
Asthma	____
Use Inhaler?	____
COPD	____
Tuberculosis	____
Endocrine (hormonal)	
Diabetes	____
Take insulin?	____
Thyroid Disease	____

Gastrointestinal	**Yes**
Ulcers	____
Hepatitis	____
When?_____	
Type?_____	
Liver Disease	____
Cirrhosis	____
Hematologic (blood)	
Stroke	____
When?_____	
Anemia	____
Prolonged bleeding	____
Leukemia	____
HIV/AIDS Positive	____
Urinary	
Urinate frequently	____
Kidney problem	____

Dermal/Musculoskeletal	
Sore Jaw Muscles/Joints	____
Arthritis	____
Artificial Joint	____
Mouth Ulcers/Sores	____

Other Conditions	
Enlarged Node/Gland	____
Use Tobacco, Alcohol	____
Atypical Facial Pain	____
Cancer/Chemo/Radiat	____

Osteoporosis	____
Bisphosphonate use	____
Previous slow healing	____
Recent travel out of U.S.	__

Have you been instructed to **premedicate** with antibiotics prior to dental treatment for any health related conditions (such as: prior infective endocarditis, artificial joints, unrepaired cyanotic congenital heart defects etc...) ____

PLEASE LIST ALL MEDICINES YOU CURRENTLY TAKE:

_____

_____

Dental Information *Circle all that apply*

Recent Oral Surgery	Tooth Sensitivity to Cold/Hot	Difficult to Numb	Anxious
Recent Swelling	Trauma to teeth current/past	Orthodontic Therapy	Headaches/Neck Pain
		Recent Dental Work	

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this notice.

Patient or Guardian _____ **Date:** _____

I understand that the information I have given today is correct to the best of my knowledge. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, including x-rays. I understand that treatment is no guarantee of success and that complications, which may result in tooth loss or necessitate further treatment, may occur. I also understand that I am to return to my dentist for a permanent restoration following the completion of root canal therapy.

Patient or Guardian _____ **Date:** _____

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Patient Registration

Today's Date: _____

Patient Information **Every line must be completed before services can be rendered**

Check: ❑Mr. ❑Mrs. ❑Ms. ❑Dr. ❑Rev

Patient's Full Name _____
First Last Middle

Nickname _____

Address _____
Street City State Zip

Date of Birth _____ Social Security No. ___-___-____ Employer _____

Primary Phone#:(___)_____ Texting: ❑ Yes ❑ No Secondary Phone #:(___)_____

By checking Yes in the Texting field above, you agree to receive SMS text messages from Fort Wayne Endodontics. Reply STOP to opt out at any time. Reply HELP for Customer Care Contact Information. Messages and data rates may apply. Message frequency will vary.

Person to Contact in Case of Emergency _____ Phone: (___)_____

Family Dentist:_____

Person Responsible for Account/Payment (Guarantor):_____

Same Address? ❑Yes ❑No

Dental Insurance Information

Name of Insured _____ ❑Male ❑Female

Relationship to Patient: ❑Self ❑Spouse ❑Parent ❑Other

Social Security No. ___-___-____Date of Birth _____ Phone (___)_____

Employer_____ Insurance Co. _____

Ins. Group No. _____ Insurance Co. Phone (___)_____

Please inform us if you have *secondary insurance coverage*.