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 #:(___)_____

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*.