

PLEASE FILL OUT COMPLETELY

CLEAR LAKE ENDODONTICS, P.A. MEDICAL AND PERSONAL HISTORY

CONFIDENTIAL

Patient Name: Social Security: Preferred Name: Birthdate: Sex: EMail: Address: City: State: Zip: Home Phone: Work Phone: Cell Phone: Employer: Position: Phone: Spouse/Parent Name: Employer: Phone: General Dentist: Referred By: Dental Insurance: Yes No Primary Dental Insurance: Employer: Group No: Subscriber Name: Subscriber Soc. Sec. No: Subscriber Birthdate: If insurance is through a retirement plan, who is the previous employer: Secondary Dental Insurance: Employer: Group No: Subscriber Name: Subscriber Soc. Sec. No: Subscriber Birthdate: Emergency Contact Person: Relationship: Phone: Physician: Phone: Is the present problem due to an accidental injury? No Yes, If yes, please give details:

1. Has the patient ever had any of the following: (Mark yes or no with an "X")

Table with 4 columns of conditions and Yes/No checkboxes. Conditions include Asthma, Lung Disease/TB, Cancer, Diabetes, Thyroid Problems, Epilepsy/Seizures, Mitral Valve Prolapse, Rheumatic Fever, Heart Trouble/Murmur, Heart Valve/Bypass, High Blood Pressure, Blood Disorder, Major Operation, Hospitalization, Blood Transfusion, HIV/AIDS, Hepatitis or Liver Disease, Joint Replacement, Stomach Ulcer, Kidney Disease, Psychiatric Treatment, Sinus Problems, T.M.J. Problems, Venereal Disease.

2. Has patient ever had or been told he/she has had

Excessive or prolonged bleeding ... A reaction to anesthetic injection ("Novocain") ... An allergic reaction to any drugs ... 3. If female, are you pregnant? Nursing? Taking birth control pills?\*

\* Please be advised that if you take antibiotics, an alternate method of birth control must be used.

4. Have you received therapy for alcoholism or drug addiction during the past 5 years? Yes No What is your weekly consumption of alcohol tobacco

5. LIST ALL PRESENT OR RECENT PRESCRIPTIONS / OVER THE COUNTER MEDICATIONS, INCLUDING SUPPLEMENTS

6. LIST ALL MEDICATION OR DRUG ALLERGIES

7. Are you allergic to any (please check if yes) Metals or Latex or Household Bleach

8. Are you required to take antibiotics prior to ALL dental treatments Yes No

9. Is there any other information about your health we should know?

I hereby grant permission to Dr. Qamar or any of his associate(s), to administer anesthetics and to employ such operative, surgical, or technical procedures, including x-rays and photographs as may be deemed necessary or advisable in the diagnosis or treatment in the case of the patient whose name appears above. I also authorize Dr. Qamar or any of his employees, associates, or any subsequent dentist, to review or copy any and all information that may be contained in this record, to include but not limited to medical history, treatment, and x-rays.

I accept full financial responsibility for services rendered by this office and understand that I am to pay in full at the completion of treatment. If the account is referred to an attorney or suit is filed to collect any sum I owe, I agree to pay costs, collection charges, and reasonable attorneys fees.

Date Signature of Patient, Parent or Guardian