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")

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

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

	Yes	No		Yes	No		Yes	No
Excessive or prolonged bleeding	❑	❑	A reaction to anesthetic injection ("Novocain")	❑	❑			
An allergic reaction to any drugs	❑	❑	Slow healing of a wound or incision	❑	❑			
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 comsumption 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. ***A $100 fee per hour will be assessed for failed/missed appointments.***

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