CENTRAL MINNESOTA ENDODONTICS, PA

Patient Personal Information

Title ________________ Nickname________________________ Birth Date __________________ Age __________
Last, First ________________________________ Marital Status _______________Gender ____________________
Address _________________________________ Home # ____________________Work #_____________________
____ Cell # ______________________Drive Lic____________________
City, State, Zip ____________________________ Student ____________________SSN _______________________
Email ___________________________________ School Name ______________________________
____ How did you hear about our practice? ______________________
Is patient responsible for paying bills? ☐ Yes ☐ No

Person responsible/guarantor for paying bills

Title ________________ Nickname________________________ Birth Date __________________ Age __________
Last, First ________________________________ Marital Status _______________Gender ____________________
Address _________________________________ Home # ____________________Work #_____________________
____ Cell # ______________________Drive Lic____________________
City, State, Zip ____________________________ SSN ______________________________
Email ____

Dental Insurance

Do you have **Primary** Dental Insurance? ☐ Yes ☐ No
Group No./Name ____
Insurance Name____
Phone # ____
Employer Name ____
Subscriber Last, First ____
Subscriber Address ____
City, State, Zip ____
Relationship to Patient ____
Birth Date ____
Subscriber ID ____

Do you have **Secondary** Dental Insurance? ☐ Yes ☐ No
Group No./Name ____
Insurance Name____
Phone # ____
Employer Name ____
Subscriber Last, First ____
Subscriber Address ____
City, State, Zip ____
Relationship to Patient ____
Birth Date ____
Subscriber ID ____

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Name: ____ DOB: ____________________

Medical Alerts

Do You Have the Following:

- ☐ Amoxicillin Allergy
- ☐ Aspirin or Ibuprofen Allergy
- ☐ Augmentin Allergy
- ☐ Epinephrine Sensitivity Allergy
- ☐ Erythromycin Allergy
- ☐ Clindamycin Allergy
- ☐ Codeine / Other Pain Killers Allergy
- ☐ Iodine Allergy
- ☐ Latex or Rubber Product Allergy
- ☐ Local Anesthetics Allergy
- ☐ Metals Allergy
- ☐ Penicillin Allergy
- ☐ Sedatives or Barbiturates Allergy
- ☐ Sulfa Drugs Allergy
- ☐ Other Allergy (list on Medical Questionnaire)

Are You Using the Following

- ☐ Antibiotics
- ☐ Anticoagulants/Blood Thinners
- ☐ Aspirin
- ☐ Cortisone/Prednisone
- ☐ High Blood Pressure Medication
- ☐ Insulin
- ☐ Motrin/Aleve/ Ibuprofen
- ☐ Oral Anti-Diabetic
- ☐ Nitroglycerin

Currently Taking or Ever Taken

- ☐ Actonel
- ☐ Aredia
- ☐ Boniva
- ☐ Fosamax
- ☐ Prolia
- ☐ Reclast
- ☐ Zometa
- ☐ Other Bisphosphonates

Check, if applicable

- ☐ Premedication Needed
- ☐ Alcohol/Drug Abuse
- ☐ Cancer/Tumor Growth
- ☐ Chemotherapy/Radiation
- ☐ Communication Issue
- ☐ Development Delay
- ☐ Learning Problems
- ☐ Organ Transplant
- ☐ Sensory Integration Disorder
- ☐ Wheel Chair

EYE, EAR, NOSE, THROAT PROBLEMS

- ☐ Canker Sores
- ☐ Cold Sores (Herpes)
- ☐ Ear Aches (Otitis)
- ☐ Frequently Dry Mouth/Sjogren
- ☐ Glaucoma
- ☐ Large Tonsils or Adenoids
- ☐ Hay Fever/Seasonal Allergies
- ☐ Hearing Impaired
- ☐ Sinus Trouble
- ☐ Vision Loss

HEART PROBLEMS

- ☐ Mitral Valve Prolapse
- ☐ Angina
- ☐ Chest Pain
- ☐ Congenital Heart Defects
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Heart Damage
- ☐ Heart Murmur
- ☐ Heart Valve Replacement
- ☐ Irregular Heart Beat
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Rheumatic Fever

LUNG PROBLEMS

- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic Cough
- ☐ COPD
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Reactive Airway Disease
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Tuberculosis

VASCULAR/BLOOD PROBLEMS

- ☐ Anemia
- ☐ Leukemia
- ☐ Excessive, Prolonged Bleeding
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Leg Bypass Surgery

GASTROINTESTINAL PROBLEMS

- ☐ Acid Reflux
- ☐ Cirrhosis
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hiatial Hernia
- ☐ Intestinal Bleeding
- ☐ Ulcers

GENITOURINARY PROBLEMS

- ☐ Dialysis
- ☐ Kidney Disease/Failure
- ☐ Urinary Tract Infections

MUSCLE/BONE/SKIN PROBLEMS

- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Back Problems
- ☐ History of Skin Problems
- ☐ Joint Problems
- ☐ Muscle Problems
- ☐ Neck Problems
- ☐ Osteoporosis

NERVOUS SYSTEM PROBLEMS

- ☐ ADD/ADHD
- ☐ Alzheimer's Disease
- ☐ Anorexia / Bulimia
- ☐ Anxiety
- ☐ Autism Spectrum Disorder
- ☐ Bipolar Disease
- ☐ Cerebral Palsy
- ☐ Dementia
- ☐ Depression
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Injury to Head
- ☐ Migraines
- ☐ Muscular Dystrophy
- ☐ Numb Areas
- ☐ Paralysis
- ☐ Parkinsons Disease
- ☐ Seizures
- ☐ Stroke
- ☐ Other Psychiatric Condition

ENDOCRINE PROBLEMS

- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Low Blood Sugar
- ☐ Thyroid Problems

IMMUNE SYSTEM PROBLEMS

- ☐ AIDS/HIV
- ☐ Lupus
- ☐ Rheumatoid Arthritis

OTHER PROBLEMS

- ☐ Jaundice
- ☐ Liver Disease
- ☐ Measles, Mumps, Chickenpox
- ☐ Other Medical Condition

CENTRAL MINNESOTA ENDODONTICS, PA

Name: ____ DOB: ____________________

Medical Questionnaire

1. Emergency Contact Name and Phone #: ____________________
2. Primary Physician Name, Address and Phone: ____________________
3. Referring Physician Name, Address and Phone: ____________________
4. Are you in good health? ☐ Yes ☐ No
5. When was your last physical examination? ____________________
6. Are you currently under care of a Physician? ☐ Yes; Condition: ☐ No
7. Have you had any serious illness, operation, accident or been hospitalized? ☐ Yes; Describe: ☐ No
8. Has there been any change in your general health in the past year? ☐ Yes; Describe: ☐ No
9. Are you currently taking any medication other than listed earlier, including OTC, vitamins or herbal remedies? ☐ Yes; Please provide a list. ☐ No
10. Have you had previous problems with general or local anesthesia? ☐ Yes; Describe: ☐ No
11. Do you have any allergies besides what was listed in the Patient Medical Information Section? ☐ Yes; Describe: ☐ No

Women Only

12. Are you pregnant or is there a chance you may be pregnant? ☐ Yes- Due Date____________ ☐ No
13. Are you currently nursing? ☐ Yes ☐ No

Family/Personal/Social History

14. Mother Healthy? ☐ Yes ☐ No; Explain:____
15. Father Healthy? ☐ Yes ☐ No; Explain: ____
16. Do you now or have you ever used:

Tobacco/Chew/e-cigarettes	☐ No	☐ Yes	Frequency _______	Number of years _______	Quit Date_______
Alcohol	☐ No	☐ Yes	Frequency _______	Last Drink _______	Quit Date _______
Recreational/Street Drugs	☐ No	☐ Yes	Frequency _______	Number of Years _______	Quit Date _______

Additional Comments

By signing below, I certify that all of the above information is true to the best of my knowledge.

______________________________________ ______________________________________

Patient's Signature (Parent/Guardian) Date Dentist/Doctor's Signature Date

INFORMATION UPDATED

______________________________________ ______________________________________

Patient's Signature (Parent/Guardian) Date Dentist/Doctor's Signature Date

CENTRAL MINNESOTA ENDODONTICS, PA

Patient Medication Form

Patient Name		ID #		DOB		Gender	__ M __ F

Medication & Dosage	Indication for Use	Start Date

Updated Form – Admin Only	
Date	Name

For Admin Use Only – Entered into QDW		
Date		Name