TULSA ENDODONTIC ASSOCIATES

New Patient Form

Patient

First Name ______________ M.I. ____ Last Name ______________ M/F ____ Date of Birth ____________

Address ______________________________ City/__________ State/_____ Zip/______________

Home Phone ______________ Business Phone ______________ Cell Phone ______________

Employed by ______________________________ Occupation ______________________

Business Address ______________________ City/ __________ State/ _____ Zip/ __________

Patient Social Security No. ______________________ Spouse Social Security No. ______________________
(if minor, parent or guardian)

Spouse Name ______________________ D.O.B. ______________ Occupation ______________
(if minor, parent or guardian)

Employed by ______________________________ Business Phone ______________

Business Address ______________________ City/ __________ State/ _____ Zip/ __________

Emergency Contact ______________________ Phone Number ______________________
(other than spouse)

If minor, Parent or Guardian ______________________ Phone Number ______________________

Name of Dentist ______________________________ Phone Number ______________________

1. Are you in good health? ☐ Yes ☐ No
2. Have you been seen by a physician in the last five years? ☐ Yes ☐ No
3. Name of Physician ______________ Phone ______________
4. Do you have any allergies or sensitivities to penicillin, local anesthetics, latex (novocaine / lidocaine), codeine, demerol, aspirin, or any other medication? ______________ ☐ Yes ☐ No
5. Are you taking drugs or medications now? If yes, please list ______________ ☐ Yes ☐ No

   ____
6. Do you premedicate with antibiotics for heart problems/joint replacement prior to dental appointment? ☐ Yes ☐ No

   If so, what did you take before today's appointment __________ What time: __________
7. Have you ever had an unfavorable reaction following dental treatment? Explain__________ ☐ Yes ☐ No

   ____
8. Have you EVER had any of the following? Please check EACH box.

☐ High Blood Pressure	☐ Mitral Valve Prolapse	☐ Ulcers
☐ Heart Attack	☐ Heart Valve Problems	☐ Diabetes
☐ Arrhythmias	☐ Heart Valve Replacement	☐ Epilepsy
☐ Pacemaker	☐ Artificial Joint	☐ Nervous Disorders
☐ Stroke	☐ Bleeding Disorder	☐ Venereal Disease
☐ Heart Defect	☐ Hepatitis	☐ Herpes
☐ Rheumatic Fever	☐ Jaundice	☐ A.I.D.S. / HIV Positive
☐ Heart Murmur	☐ Asthma	☐ Glaucoma
☐ Liver Disorder	☐ Respiratory Problems/TB	☐ Chemical Dependency

9. Have you any other serious illness? ☐ Yes ☐ No

   If yes, please state what: ______________________
10. Female patients: Are you pregnant? ☐ Yes ☐ No

    Please state how far along you are: ______________________

Date ______________ Patient Signature/ (if minor, parent or guardian) ______________________

Update ______________ Patient Signature/ (if minor, parent or guardian) ______________________

Update ______________ Patient Signature/ (if minor, parent or guardian) ______________________