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) _____