Wallis E. Andelin, D.D.S., M. S. **ENDODONTICS**

PLEASE TURN OFF CELL PHONES

PATIENT INFORMATION

Last Name_____ (Mr. Dr. Mrs. Ms. Miss) First Name_____ MI_____
(Please Circle)

Home Phone (____)_____ Work Phone (____)_____ Cell Phone (____)_____

Home Address_____ City_____ Zip_____

Social Security #_____ Birthdate_____ Age_____

Patient's Employer_____ Occupation_____

Employer's Address_____ City_____ Zip_____

Name of Spouse_____ Spouse Employed by_____

Business Address_____ City & Zip_____ Phone_____

Name of Referring Dentist_____

If patient is a minor, who is legally responsible?_____

IN CASE OF AN EMERGENCY, PLEASE CONTACT_____ Phone (____)

Authorization to Release Information: I hereby authorize Dr. Wallis E. Andelin, to provide any insurance company(s) administrators, and consulting health professionals information concerning dental health care and treatment, as needed.
Date_____ Patient/Parent SignatureX_____

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING (IF TWO POLICIES, COMPLETE BOTH PORTIONS):

Insured Person_____ Insured Person_____
Name of Insurance Co._____ Name of Insurance Co._____
Group #_____ Soc. Sec. #_____ Group #_____ Soc. Sec. #_____
If this insurance coverage is through your spouse, what is his/her birthday?_____

Authorization to Pay Benefits Directly to Dentist: I hereby authorize payment of the dental benefits, otherwise payable to me, directly to Dr. Wallis E. Andelin.
Date_____ Patient/Parent SignatureX_____

MEDICAL HISTORY

PLEASE COMPLETE THIS CONFIDENTIAL FORM ON BOTH SIDES. IT IS VERY IMPORTANT TO ANSWER ALL OF THE QUESTIONS CORRECTLY. NONE OF THE INFORMATION WILL BE USED TO DENY DENTAL TREATMENT.

Name of your Physician_____ Phone (____)_____ Date of Last Exam_____

HAVE YOU BEEN UNDER THE CARE OF A MEDICAL DOCTOR DURING THE PAST TWO YEARS:.....YES NO
If yes, for what?_____

HAVE YOU BEEN A PATIENT IN THE HOSPITAL DURING THE PAST TWO YEARS?.....YES NO
If yes, please explain_____

HAVE YOU EVER HAD ANY EXCESSIVE BLEEDING REQUIRING SPECIAL TREATMENT?.....YES NO
If yes, please explain_____

ARE YOU NOW TAKING, OR HAVE YOU TAKEN ANY MEDICINE OR DRUGS DURING THE PAST TWO YEARS?.....YES NO
If yes, please list_____

ARE YOU ALLERGIC TO (i.e. ITCHING, RASH, SWELLING OF HANDS, FEET OR EYES) OR MADE SICK BY ANY DRUGS OR MEDICATION?.....YES NO
If yes, please list_____

ARE YOU ALLERGIC TO ANY METALS (SILVER, GOLD, MERCURY NICKEL, STAINLESS STEEL)?..... YES NO
If yes, please list_____

ARE YOU ALLERGIC OR SENSITIVE TO ANY LATEX PRODUCTS (SUCH AS RUBBER GLOVES)?.....YES NO
If yes, please explain_____

ARE YOU ALLERGIC OR SENSITIVE TO ANY OTHER SUBSTANCES OR MATERIALS?.....YES NO
If yes, please explain_____

WHEN YOU WALK UP STAIRS OR TAKE A WALK, DO YOU EVER HAVE TO STOP BECAUSE OF PAIN IN YOUR CHEST, SHORTNESS OF BREATH, OR BECAUSE YOU FEEL VERY TIRED?..... YES NO

(PLEASE TURN OVER)

DO YOU HAVE OR HAVE YOU EVER HAD:

	YES	NO		YES	NO
HEART DISEASE OR ATTACK	☐	☐	TUBERCULOSIS (TB)	☐	☐
HEART SURGERY	☐	☐	ASTHMA	☐	☐
HEART MURMUR	☐	☐	SINUS TROUBLE	☐	☐
MITRAL VALVE PROLAPSE	☐	☐	DIABETES	☐	☐
RHEUMATIC FEVER	☐	☐	THYROID DISEASE	☐	☐
ARTIFICIAL HEART VALVE	☐	☐	ARTHRITIS	☐	☐
HEART PACEMAKER	☐	☐	CORTISONE MEDICINE	☐	☐
HIGH BLOOD PRESSURE	☐	☐	CANCER	☐	☐
STROKE	☐	☐	BLOOD TRANSFUSION	☐	☐
ARTIFICIAL JOINT	☐	☐	HEMOPHILIA	☐	☐
ULCERS	☐	☐	EPILEPSY OR SEIZURES	☐	☐
HEPATITIS	☐	☐	FAINTING OR DIZZY SPELLS	☐	☐
LIVER DISEASE	☐	☐	DRUG ADDICTION/ALCOHOLISM	☐	☐
HIV POSITIVE	☐	☐	IRRITABLE BOWEL SYNDROME	☐	☐
TMJ	☐	☐	UPPER GI PROBLEMS	☐	☐

DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED? ....YES NO

If yes, please explain_____

HAVE YOU EVER TAKEN BONIVA OR FOSAMAX?.....YES NO

ARE YOU NERVOUS ABOUT THIS ROOT CANAL TREATMENT? .....YES NO

ARE YOU CLAUSTROPHOBIC? .....YES NO

WOMEN: IS THERE ANY POSSIBILITY THAT YOU ARE PREGNANT NOW? .....YES NO

If yes, when are you due? _____

ARE YOU CURRENTLY TAKING BIRTH CONTROL PILLS? .....YES NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health, or if my medications change, I will inform the doctor at the next appointment without failure.

I, the undersigned, being the patient, parent or guardian of the above minor patient, consent to the performing of whatever procedure may be decided upon to be necessary or advisable in the opinion of the doctor. Root canal treatment is an ATTEMPT to save a tooth, which may otherwise require extraction. Although root canal treatment has a high degree of success, IT CANNOT BE GUARANTEED. Occasionally a tooth, which has had root canal treatment, may require retreatment, surgery or even extraction. I also understand that upon completion of root canal treatment in this office I will be referred to my general dentist for permanent restoration, such as a crown or filling.

DATE_____PATIENT/CUSTODIAL PARENT SIGNATURE X_____

REMARKS:

Signature of Dentist_____

MEDICAL HISTORY UPDATE

DATE	ADDITIONS	SIGNATURE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____