Vaughn Endodontics - Patient Medical Information

Patient Name: ________________________________

Emergency Contact: ______________________________ **Relationship**: ______________________________________

Emergency Phone #: __________________ ____ **Pharmacy Preference & Phone #:** _________________________________

1. Has there been any change in your general health within the past year? Yes No

   If "yes" please specify ____

2. Are you under the care of a physician for a current problem? Yes No

   If "yes" please specify ____

3. Have you been hospitalized within the past five years? Yes No

   If "yes" please specify ____

4. Are you taking any medications or drugs? Yes No

   *If yes you may use the back of this page to list additional medications or you may provide a separate list

5. Have you received therapy for alcoholism or drug addiction during the past 5 years? Yes No

6. **Have you ever had any *ALLERGIC* or adverse reactions to anesthetics?** Yes No

   If yes please specify: ____

7. **Are you ALLERGIC to antibiotics, latex, iodine or any other medications?** Yes No

   If yes please specify: ____

8. Have you ever required a blood transfusion? Yes No

   If yes please explain: ____

9. Have you ever had surgery and/or radiation for a tumor, growth or other condition? Yes No
10. Have you ever been tested for HIV infection(AIDS)? Result of test: Date: Positive Negative
11. Are you required to take premeds prior to dental treatment for existing? Yes No

    If yes, have you taken them today? Yes No

Which of the following conditions apply to you?

__High Blood Pressure
__Congenital Heart disease
__Hepatitis/ Type?__
__Asthma
__Stomach, ulcers, colitis
__Liver disease
__Heart Murmur or)MVP)
__ Chest Pains
__Epilepsy
__Sinus Problems
__Kidney problems
__Venereal disease
__Cancer
__Rheumatic Fever
__Radiation Therapy
__TMJ
__Thyroid Problems
__Fainting or seizures
__Osteoporosis
__Diabetes Type __
__Psychiatric Treatment
__Tuberculosis
__Prosthetic Heart Valve
__Rheumatic Heart Disease
__Blood Disorder such as Anemia
__Cardiovascular disease: heart attack, stroke, by-pass
__Joint Replacement When? ______
__Other

Women: Pregnant? __Yes __No Nursing? __ Birth control pills? __Yes __No *If taking antibiotics an alternate method of birth control must be used.

I give my permission to take digital x-rays of my procedure for purposes of completing my medical record, patient education or teaching purposes. ____ initial

I certify that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. ____ initial

I authorize my insurance company to pay insurance benefits directly to the dentist. ____ initial
Any balance regarding this account remains the responsibility of the patient or legal guardian. I understand that if my account is referred to a collection agency or attorney, I am responsible for any fees accrued, as well as any other charges that may develop from this action.

Signature of Patient or Legal Guardian if under 18yrs: ______________________________ Date: ____________