Honolulu Endodontics, Inc.

Welcome. Our goal is to make your visit as pleasant as possible. Please fill out this form completely so we can serve you better.

Today's Date: _____

Patient Information

Patient Name: ❑ Mr ❑ Mrs ❑ Ms ❑ Dr _____
(check one) First Middle Initial Last

Preferred Name: _____ Birthdate: _____ Marital Status: ❑ Single ❑ Married

Social Security Number: _____ Email address: _____

Address: _____
Street City, State Zip Code

Phone numbers: Home _____ Work: _____ Ext.: _____ Cell: _____
Other: _____ Best time to call: _____

Employer: _____ Address: _____

Occupation: _____ Years there? _____

Referral Information

Whom may we thank for referring you here? _____ Your Dentist's Name: _____

Spouse or Responsible Party Information

Name: _____ Relationship: _____
First Middle Last

Birthdate: _____ Social Security #: _____ Work Phone: _____

Address: _____
Street City, State Zip Code

Insurance Information

Primary Dental Insurance Carrier Name: _____ Group#: _____

Insurance Company Address: _____
Street City, State Zip Code

Insurance Company Phone: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Relationship to patient: _____ Employer: _____

Secondary Dental Insurance Carrier Name: _____ Group#: _____

Insurance Company Address: _____
Street City, State Zip Code

Insurance Company Phone: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Subscriber Social Security #: _____

Relationship to patient: _____ Employer: _____

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Medical History

In case of emergency contact: _____ Work #: _____ Home #: _____

Relationship: _____

Personal Physician: _____ Phone: _____

Your current physical health is: Good _____ Fair _____ Poor _____
Are you currently under physician's care? _____ If so, for what?_____

Please list any medications you are taking: _____

WOMEN: Are you taking birth control pills? _____ Are you pregnant? _____ Week #: _____
Are you nursing? _____

Please check if you ever had any of the following diseases or medical problems?

- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Bones/Joints
- ❑ Artificial Valves
- ❑ Asthma
- ❑ Blood Transfusion
- ❑ Cancer/Chemotherapy
- ❑ Colitis
- ❑ Congenital Heart Defect
- ❑ Diabetes
- ❑ Difficulty Breathing
- ❑ Drug/Alcohol Abuse
- ❑ Emphysema
- ❑ Epilepsy/Seizures/Fainting Spells
- ❑ Fever Blisters/Cold Sores/Herpes
- ❑ Glaucoma
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hemophilia/Abnormal Bleeding
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV+/ AIDS
- ❑ Kidney Problems
- ❑ Low Blood Pressure
- ❑ Mitral Valve Prolapse
- ❑ Pacemaker
- ❑ Psychiatric Problems
- ❑ Radiation Treatment
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Severe/Frequent Headaches
- ❑ Shingles
- ❑ Sinus Problems
- ❑ Stroke
- ❑ TB
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Pre-Medication for dental treatment

❑ Are you now or have you ever taken diet pills? If so, what type _____

Have you been hospitalized? _____ Reason: _____

Are you allergic to any of the following:

- ❑ Aspirin
- ❑ Codeine
- ❑ Dental Anesthetics
- ❑ Erythromycin
- ❑ Latex
- ❑ Penicillin
- ❑ Tetracycline
- ❑ Bleach

Please list any other drugs you may be allergic to: _____
Dental History: Are you in pain currently? _____ How long? _____
Are your teeth sensitive to: Cold _____ Heat _____ Biting _____
Have you had pain or discomfort in the jaw joint (TMJ/TMD)? _____
Have you had any swelling? _____ Gums Bleeding? _____

I understand that the above information is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform Honolulu Endodontics, Inc. of any changes in my medical status. I authorize release of medical information if necessary.

Signature _____ Date _____