Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____

Nickname: _____ Gender: _____ Date of Birth:_____ Age: _____

Address: _____Town:_____ State: _____ Zip: _____

Occupation:_____ **General Dentist**: _____

EMERGENCY CONTACT:

Name: _____

Phone #: _____

For minors or wards: Parent or Legal Guardian

Name: _____

Relationship: _____

Cell Phone*:_____ Email*:_____

Home Phone:_____ Work:_____

*By providing your email address or cell phone number, you are opting in to receive appointment reminders, billing inquiries, and other non-sensitive electronic communication (email and/or SMS) from Circle Endodontics. We will never use it for advertising or promotion and will only share your information with a third party for insurance billing or collection purposes. Standard messaging rates may apply; we are not responsible for any charges incurred by your mobile carrier. A copy of our Electronic Communication Policy is available on our website at https://circleendo.com. To opt out now write "OPT-OUT"

Preference for calls:
☐ Cell ☐ Home ☐ Work

Payments/Billing:
☐ Text (SMS)* ☐ Email* ☐ Mail

Appointment Reminders:
☐ Text (SMS)* ☐ Email* ☐ Phone

Dental Insurance Information

Primary Dental Insurance:_____ Subscriber ID or SSN#:_____

Subscriber Name:_____ Subscriber Birthdate:_____

Relation: Self Spouse Dependent Subscriber's Employer:_____

Secondary Dental Insurance:_____ Subscriber ID or SSN#:_____

Subscriber Name:_____ Subscriber Birthdate:_____

Relation: Self Spouse Dependent Subscriber's Employer:_____

By signing below, I certify that I (or my dependent) have insurance coverage and assign payment directly to Circle Endodontics for services rendered. I understand that on the date of service, I am responsible for payment of any co-payments or deductibles. I hereby authorize Circle Endodontics to release the necessary information to secure payment of benefits. I authorize the use of this signature on insurance submissions.

X_____ Date: _____
Signature (Patient, parent or legal guardian)

Dental History

Have you been advised by a physician to take **antibiotics before your dental cleanings** due to a medical condition?

If yes, what condition?_____What antibiotic?_____

How **ANXIOUS** are you about dental treatment? Not at all..... slight worry.....moderate worry .....severe worry.....panic

How much **PAIN** are you in today? No pain ..... mild pain.....moderate pain.....severe pain .....worst pain

Have you ever had **problems with dental treatment** in the past? If YES, please explain:_____

_____

OVER→

Medical History

Primary Care Physician: _____ Last visit_____ /_____

In the past 5 years have you had a **serious illness, operation or hospitalization**? YES / NO

If yes, explain:_____

Drug Allergies? YES / NO *Please list:* _____

Other Allergies? YES / NO *List:* _____

YES / NO **Blood thinners?** *Aspirin, Warfarin/Coumadin, clopidogrel/Plavix, rivaroxaban/Xarelto, Eliquis, dabigatran/Pradaxa*

YES / NO **Bisphosphonate Medication *(for OSTEOPOROSIS, METASTATIC CANCER, etc)***: *alendronate (Fosamax), risedronate (Actonel), ibandronate (Boniva), zolendronate (Reclast), and denosumab (Prolia) denosumab (Xgeva), pamidronate (Aredia), and zolendronate (Zometa)*] **How long?**_____

Current medications ***we can scan a list if you have one*:**_____

_____

Have you ever been diagnosed with or treated for any of the following? *Please circle Y = YES, or N = NO*

Heart (Cardiac) Health
- ☐ Artificial (Prosthetic) heart valve
- ☐ Angina (chest pain)
- ☐ Congenital heart disease
- ☐ Coronary artery disease
  CABG or Stent?_____
- ☐ Congestive heart failure
- ☐ Damaged heart valves
- ☐ Heart attack, when?_____
- ☐ Heart murmur/rhythm disorder
- ☐ High or low blood pressure
- ☐ Infective endocarditis
- ☐ Pacemaker/Implanted Defibrillator

Blood (Circulatory) Health
- ☐ Anemia, type?_____
- ☐ Bleeding disorder / clotting problem
  Type?_____

Brain (Neurological)/ Mental Health
- ☐ Stroke When?_____
- ☐ Seizures or epilepsy
- ☐ Mental health disorder
  Type:_____
- ☐ Neurological disorder
  Type:_____
- ☐ Traumatic brain injury or concussion

Breathing (Respiratory) Health
- ☐ Asthma
- ☐ Emphysema
- ☐ Diagnosed Sleep apnea
- ☐ Sinus trouble
- ☐ Tuberculosis? When? _____

Cancer
- ☐ Type:_____STAGE:_____
  Date of diagnosis: _____
- ☐ Chemotherapy
- ☐ Radiation

Digestive GI Health
- ☐ Crohn's Disease
- ☐ Clostridium difficile (c. diff) infection
- ☐ Gastric bypass
- ☐ Reflux, heartburn (GERD)
- ☐ Stomach ulcer
- ☐ Ulcerative colitis

Immunologic / Allergy
- ☐ Autoimmune Disease
  Type: _____
- ☐ Diabetes: TYPE:_____
- ☐ Epi Pen
- ☐ Immune deficiency
- ☐ Immunosuppressant Medication

WOMEN ONLY: Are you currently:
Taking birth control pills?..... Y / N
Pregnant?..... Y / N
If yes, number of weeks_____
Nursing?..... Y / N

Metabolic
- ☐ Thyroid problems_____
- ☐ Kidney disease_____
- ☐ Hepatitis? Type_____
- ☐ Liver disease or Jaundice
- ☐ Organ transplant_____
  When?_____

Skeletal
- ☐ Osteoporosis
- ☐ Joint replacement _____
- ☐ Chronic pain_____

TMJ Screening:
- ☐ Diagnosed TMD or TMJ disorder..
- ☐ Clenching or grinding teeth
- ☐ Wear a night guard
- ☐ Jaw clicks or pops
- ☐ Hard to open mouth
- ☐ Serious injury to head or mouth
- ☐ History of jaw stuck open

Other conditions, diseases or problems not listed above:_____

***By signing below*,** I acknowledge that the information disclosed in this form is accurate and complete

Signature** _____**Date:** _____

Must be **18 or over to sign above. If signed by parent or patient representative, please complete the following:

Patient Representative's Name:_____ **Relationship to Patient:**_____

Reviewed by Doctor: Date: