

PLEASE FILL OUT COMPLETELY

CLEAR LAKE ENDODONTICS, P.A. MEDICAL AND PERSONAL HISTORY

CONFIDENTIAL

Patient Name: Social Security: Preferred Name: Birthdate: Sex: Address: City: State: Zip: Home Phone: Work Phone: Cell Phone: Pager: Employer: Position: Phone: Spouse/Parent Name: Employer: Phone: General Dentist: Referred By: Dental Insurance: Yes No Primary Dental Insurance: Employer: Group No: Subscriber Name: Subscriber Soc. Sec. No: Subscriber Birthdate: If insurance is through a retirement plan, who is the previous employer: Secondary Dental Insurance: Employer: Group No: Subscriber Name: Subscriber Soc. Sec. No: Subscriber Birthdate: Emergency Contact Person: Relationship: Phone: Physician: Phone: Is the present problem due to an accidental injury? No Yes, If yes, please give details:

1. Has the patient ever had any of the following: (Mark yes or no with an "X")

- Asthma Yes No Mitral Valve Prolapse Yes No Major Operation Yes No Stomach Ulcer Yes No Lung Disease/TB Yes No Rheumatic Fever Yes No Hospitalization Yes No Kidney Disease Yes No Cancer Yes No Heart Trouble/Murmur Yes No Blood Transfusion Yes No Psychiatric Treatment Yes No Diabetes Yes No Heart Valve/Bypass Yes No HIV/AIDS Yes No Sinus Problems Yes No Thyroid Problems Yes No High Blood Pressure Yes No Hepatitis or Liver Disease Yes No T.M.J. Problems Yes No Epilepsy/Seizures Yes No Blood Disorder Yes No Joint Replacement Yes No Venereal Disease Yes No Ever Taken Phen-fen Yes No

2. Has patient ever had or been told he/she has had

- Excessive or prolonged bleeding ... Yes No A reaction to anesthetic injection ("Novocain") .... Yes No An allergic reaction to any drugs .... Yes No Slow healing of a wound or incision ..... Yes No 3. If female, are you pregnant? ..... Yes No Nursing? ..... Yes No Taking birth control pills?\* Yes No

\* Please be advised that if you take antibiotics, an alternate method of birth control must be used.

- 4. Have you received therapy for alcoholism or drug addiction during the past 5 years? Yes No What is your weekly consumption of alcohol tobacco 5. List all present or recent prescriptions / over the counter medications, including supplements

6. List all medication or drug allergies

- 7. Are you sensitive to any (please check) Metals or Latex or Household Bleach 8. Are you required to take antibiotics prior to ALL dental treatments Yes No 9. Is there any other information about your health we should know?

I hereby grant permission to Dr. Qamar or any of his associate(s), to administer anesthetics and to employ such operative, surgical, or technical procedures, including x-rays and photographs as may be deemed necessary or advisable in the diagnosis or treatment in the case of the patient whose name appears above. I also authorize Dr. Qamar or any of his employees, associates, or any subsequent dentist, to review or copy any and all information that may be contained in this record, to include but not limited to medical history, treatment, and x-rays.

I accept full financial responsibility for services rendered by this office and understand that I am to pay in full at the completion of treatment. If the account is referred to an attorney or suit is filed to collect any sum I owe, I agree to pay costs, collection charges, and reasonable attorneys fees.

Date

Signature of Patient, Parent or Guardian