

Today's Date \_\_\_\_\_

Chart # \_\_\_\_\_



**Patient Info**

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License or ID# \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Please provide us with your phone numbers and check the box below where you prefer we contact you.  
May we leave a message?  Yes  No

Home phone # \_\_\_\_\_  Work phone # \_\_\_\_\_ x \_\_\_\_\_  Cell # \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Sex  Male  Female Date of Birth \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_  Married  Single  Divorced  Separated  Minor

**Insurance Information**

Who is financially responsible for this account?  You  Spouse  Significant Other  Parent or Guardian

Who holds the insurance?  You  Spouse  Significant Other  Parent or Guardian

Primary Dental Insurance Policy Holder's Name \_\_\_\_\_

Policy Holder's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Policy Holders ID \_\_\_\_\_

Dental Insurance Company Name \_\_\_\_\_ Insurance Verification Ph # \_\_\_\_\_

Dental Insurance Group # \_\_\_\_\_ Employer or Group Name \_\_\_\_\_

Claims Mailing Address \_\_\_\_\_

Your privacy is assured and our privacy policies are posted. All information contained on this form is considered confidential.

Reason for today's visit

\_\_\_\_\_  
\_\_\_\_\_

Your Primary Care Physician's Name \_\_\_\_\_ Telephone # \_\_\_\_\_

Date of your last visit \_\_\_\_/\_\_\_\_/\_\_\_\_ Reason for last visit \_\_\_\_\_

Your General Dentist's Name \_\_\_\_\_

Who may we thank for your referral to our office \_\_\_\_\_

Emergency contact Information  Spouse  Significant Other  Parent or Guardian  Other \_\_\_\_\_

Name \_\_\_\_\_ Telephone # \_\_\_\_\_



Patient Name \_\_\_\_\_ Date \_\_\_\_\_ Chart # \_\_\_\_\_

Please check yes or no to indicate if you have had any of the following conditions or treatments:

|                                   |  |                             |  |                        |  |
|-----------------------------------|--|-----------------------------|--|------------------------|--|
| Alcohol Dependency                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes Type II            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies (Seasonal)              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prolonged Bleeding     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or Dizziness       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you pregnant or nursing       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Are you using oral contraceptives | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis/Rheumatism              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves           | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Joints                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type _____        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of Breath    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV/AIDS                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Transfusion                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hives or Skin Rash          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach Ulcer          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hormone Replacement Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency               | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Feet or Ankles | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemo-Therapy                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaundice                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen Glands         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Lesions          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone/Steroid Treatments      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes Type I                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Disorder            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____            |  |

Are you allergic or have you reacted adversely to:

Novacaine  Latex  Adhesives or Tape  Codeine  Iodine  Sulfa Drugs  Penicillin  Barbiturates  Aspirin  Other \_\_\_\_\_

Did or do you smoke?  Yes  No How many packs a day? \_\_\_\_\_ How many years? \_\_\_\_\_ Quit date \_\_\_\_/\_\_\_\_/\_\_\_\_

List medications and herbal remedies you are taking on a regular basis:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List hospitalizations, serious illnesses, and surgeries for the past 5 years (list date and procedures):

\_\_\_\_\_  
 \_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Pharmacy Phone # \_\_\_\_\_

Consent for Assignment of Benefits and treatment: I certify that me or my dependents have insurance coverage with the above named carrier and I assign directly to Uptown Endodontics, PA all insurance benefits, if any, otherwise payable to me, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named practice, its agents, and assignees may use my health care information and may disclose such information to above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I grant permission for the above named endodontists and their assistants to render care in the diagnosis and/or treatment of my dental conditions and release related information to my 3<sup>rd</sup> party payers, physician, and/or emergency medical personnel and as required by law.

\_\_\_\_\_  
 Signature of Patient, Parent, Legal Guardian or Personal Representative

\_\_\_\_\_  
 Printed name of Patient, Parent, Legal Guardian or Personal Representative

Reviewed by Dr. \_\_\_\_\_ Date \_\_\_\_\_ Assistant \_\_\_\_\_

- Thank you for entrusting us with your dental health -