Moreno Valley Endodontics
24099 Postal Ave. Suite 101
Moreno Valley, CA 92553
(951) 601-1290 FAX (951) 601-1292

INFORMATION REQUIRED FOR CASE HISTORY RECORD
THIS COMPLETE CONFIDENTIAL RECORD IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH

Have you ever been a patient in this office before? YES ☐ NO ☐ Approximate Date: _____

Has a family member been seen in this office before? Name: _____

PATIENT: _____ (last name) _____ (first) _____ (middle) DATE: _____

Residence Address: _____

Phone: _____ City: _____ Zip Code: _____

CIRCLE ONE: MISS MRS. MR. DR. MS. CHILD E-MAIL: _____

CIRCLE ONE: SINGLE MARRIED SEPARATED DIVORCED WIDOWED

Date of Birth: _____ Age: _____ Social Security Number: _____ Drivers Lic. #: _____

If Student, school attending: _____

Occupation: _____ Employer: _____

Business Address: _____ City: _____ Zip: _____ Phone: _____

Phone Number where you can be reached during the day: _____

IF PATIENT IS MARRIED COMPLETE THIS PORTION

Spouse's Name: _____
Spouse's Occupation: _____ Soc. Sec. No.: _____
Spouse's Employer: _____ Phone: _____
Address: _____
City: _____ Zip: _____

IF PATIENT IS A SINGLE MINOR (under 21 years) COMPLETE THIS PORTION

Parent or Guardian's Name: _____
Person Financially Responsible: _____ Soc. Sec. No.: _____
Spouse's Employer: _____ Phone: _____
Address: _____
City: _____ Zip: _____

Name of nearest living relative not living with you: _____ Relationship: _____

Address: _____ Phone: _____

Family Dentist: _____ D.D.S.

City: _____ Phone: _____

PRIMARY
Insurance Information

Dental _____
Address _____
Name of Policy Holder _____
Birthdate of Policy Holder _____
S.S. of Policy Holder _____
Group # _____

SECONDARY
Insurance Information

Dental _____
Address _____
Name of Policy Holder _____
Birthdate of Policy Holder _____
S.S. of Policy Holder _____
Group # _____

MEDICAL HISTORY

(Please circle Y - yes or N - no)

PLEASE FILL OUT FORM AS COMPLETELY AS POSSIBLE

Physician _____ Phone _____

Last physical examination (date) _____ Weight _____ Do you smoke? _____ Y N

Are you in good health? _____ Y N Any change in your health in the past 12 months? _____ Y N

Are you under the care of a physician _____ Y N If yes, for what? _____

Are you now using any medication or drugs? Please note _____ Y N

Do you now or have you ever used recreational drugs or habitually use any controlled substance? _____ Y N

Have you ever been hospitalized? ___ Y N Explain _____

had a serious illness? _____ Y N Explain _____

had an operation? _____ Y N Explain _____

Are you allergic to any medications, foods, household bleach or other substances? _ Y N Please list _____

Have you ever had any problems with previous dental treatment? _____ Y N

Please explain _____ TMJ Problems ___ Y N

Are you sensitive to latex? _____ Y N

Have you ever taken prescription drugs, Fen-Phen, Redux, or other weight loss products? _____ Y N

Females: Are you pregnant or using birth control pills? _____ Y N

Do you have, or have you ever had:

Eye Trouble	_____	Y N	Ulcer	_____	Y N	High blood pressure	_____	Y N
Anemia	_____	Y N	Diabetes	_____	Y N	last reading and date	_____	
Glaucoma	_____	Y N	circle: Insulin? Oral meds?			Liver Disease	_____	Y N
Kidney/Bladder trouble	_____	Y N	Diet controlled?			Cancer	_____	Y N
Sinus Problems	_____	Y N	Rheumatic fever	_____	Y N	Chemo or Radiation therapy	_____	Y N
Heart trouble	_____	Y N	Bleeding Problems	_____	Y N	Prosthetic joint replacement	_____	Y N
Pacemaker	_____	Y N	Hepatitis (Type:)	_____	Y N	Fainting	_____	Y N
Heart valve replacement	_____	Y N	HIV Positive	_____	Y N	Sexually transmitted disease	_____	Y N
Asthma	_____	Y N	Do you have aids?	_____	Y N	Women: are you pregnant?	_____	Y N
Allergies	_____	Y N	Seizures/Epilepsy	_____	Y N	month	_____	
Arthritis	_____	Y N	Heart murmurs	_____	Y N	do you think you are pregnant?	___	Y N
Thyroid problems	_____	Y N	Heart surgery/Bypass	_____	Y N	Require antibiotic premedication	_____	Y N
Strokes	_____	Y N	Tuberculosis (TB)	_____	Y N	for heart condition or joint replacement.		

Have you ever taken Fosamax,Boniva,Actonel or any cancer medications containing bisphosphonates? _____ Y N

Please explain any yes answers: _____

Any other diseases or illnesses not mentioned above: _____

I verify that the above information is correct and complete to the best of my knowledge.

CONSENT

1. The undersigned herby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient) _____. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemend fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 1/2% finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be obtained.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.
6. I authorize the use of my social security number to file my dental claim.

Date _____ Patient / Guardian's Signature _____

Date _____ Doctor's Signature _____

Changes in health _____ Date _____ Doctor's Signature _____

Changes in health _____ Date _____ Doctor's Signature _____