SC ENDODONTICS, INC. 2900 Bristol St, D105 Costa Mesa, CA 92626 714-668-1620

PATIENT INFORMATION

❑ Mr. ❑ Mrs. ❑ Miss ❑ Dr. Last Name: _____ M.I.: ___ First Name: _____

Sex: ❑ Male ❑ Female Birth Date: _____ Age: _____ Soc. Sec. #: _____

Street: _____ City:_____ State: ____ Zip: _____

Cell Phone: _____ Home: _____ Work: _____

Email: _____ Employer: _____ Phone: _____

Emergency Contact Name: _____ Relation: _____ Phone: _____

Referring Dentist or Office Name: _____ Phone: _____

How did you hear about us? ❑ Insurance Co. ❑ Your Referring Dentist ❑ Internet Search ❑ Yelp ❑ Phone Book

❑ Former Patient (name: _____) ❑ Friend/Family (name: _____) ❑ Other: _____

Who will be responsible for your account? ❑Self (If self, skip to next section) ❑Spouse ❑Parent ❑Other: _____

Last Name: _____ M.I.: ___ First Name: _____

(Please fill out below if contact info is different than one above, otherwise skip to Dental Insurance/financial section):

Street: _____ City:_____ State: ____ Zip: _____

Cell Phone: _____ Home: _____ Work: _____

❑**DENTAL INSURANCE** OR ❑**CASH/CHECK/CREDIT CARD** OR ❑**PAYMENT PLAN (CareCredit)** ❑**OTHER:** _____

Primary Insurance Name: _____ Phone: _____ ❑ DMO/HMO ❑ PPO ❑ [illegible]

Subscriber Name: _____ Member ID #: _____ Group #: _____

Relation To Patient: _____ Birth Date: _____ Soc. Sec. #: _____ Employer: _____

Secondary Insurance Name: _____ Phone: _____ ❑DMO/HMO ❑PPO ❑ [illegible]

Subscriber Name: _____ Member ID #: _____ Group #: _____

MEDICAL HISTORY INFORMATION **Have you had or do you currently have:**

(Prob.= Problem, D's = Diseases, G.I.= Gastrointestinal)

Heart Disease	❑ Yes ❑ No	Stroke	❑ Yes ❑ No	Organ Transplant	❑ Yes ❑ No
Heart Murmur / Mitral Valve Prolapse	❑ Yes ❑ No	Angina / Heart Attack	❑ Yes ❑ No	Eating Disorders	❑ Yes ❑ No
Joint Replacement / Screw / Implant	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No	Epilepsy / Seizures	❑ Yes ❑ No
Rheumatic Fever	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Sinus Problem	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Kidney / Bladder Disease	❑ Yes ❑ No	Asthma	❑ Yes ❑ No
Hepatitis / Liver Disease	❑ Yes ❑ No	Cholesterol	❑ Yes ❑ No	Pregnant, Nursing	❑ Yes ❑ No
Bisphosphonates medication(Oral/IV)	❑ Yes ❑ No	Bruising / Bleeding Prob.	❑ Yes ❑ No	Substance Abuse	❑ Yes ❑ No
Osteoporosis	❑ Yes ❑ No	Stomach Ulcers / G.I. Prob.	❑ Yes ❑ No	Mental Health Prob.	❑ Yes ❑ No
Surgeries / Hospitalization	❑ Yes ❑ No	Tuberculosis / Lung Prob.	❑ Yes ❑ No	HIV / AIDS	❑ Yes ❑ No
Arthritis / Rheumatism	❑ Yes ❑ No	Radiation / Chemotherapy	❑ Yes ❑ No	Sexual Transmitted D's	❑ Yes ❑ No
Auto Immune Disease	❑ Yes ❑ No	Cancer / Tumors	❑ Yes ❑ No	Other Condition	❑ Yes ❑ No
Thyroid Disease	❑ Yes ❑ No				

If **Yes** to any, please explain: _____

Has your physician/cardiologist instructed you to pre-medicate with **antibiotics** prior to a dental appointment? ❑ Yes ❑ No

Medications presently taking (bisphosphonates, blood thinners, birth control, over-the-counter herbs and supplements):

Allergic to any drugs (penicillin), or substances (latex): _____

I certify that the above information is updated and correct to the best of my knowledge. I will not hold my dentist, or other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____/_____ _____/_____

Patient Signature (or parent / guardian of a minor) Date Dentist Signature Date