CYPRESS ENDODONTICS, PLLC

PATIENT INFORMATION

(Please print in legible writing)

Today's Date: _____

Patient's Name: _____ Gender: Male Female
Title First Middle Last

Address: _____
Street Apt# City/State/Zip Code

Hm Phone #: _____Cell Phone #: _____Wk Phone #:_____

Date of Birth: _____Social Security #: _____

E-mail: _____

Patient Employed By: _____

How did you hear about us? _____

Emergency Contact _____ Phone#_____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT (if other than patient)

Name _____
Title First Middle Last
DOB: _____SSN:_____Relationship:_____

Address: _____
Street Apt# City/State/Zip Code

Hm Phone #: _____Cell Phone #: _____Wk Phone #:_____

E-mail: _____

Employed By: _____ Occupation: _____

DENTAL INSURANCE INFORMATION

Primary Dental Carrier:

Insurance Co.:_____
Group#_____Phone:_____

Employer Name:_____
Insured's Name:_____

Date of birth_____Soc. Sec._____
Relationship to patient:_____
Subscriber#_____

Secondary Dental Carrier

Insurance Co. _____
Group#_____Phone:_____

Employer Name:_____
Insured's Name:_____

Date of birth_____Soc.Sec._____
Relationship to patient:_____
Subscriber #_____

MEDICAL HISTORY

Patient Name: _____
Title First Middle Last

1. Primary Physician's Name:_____ Phone:_____

Address: _____
Street Suite# City/State/Zip

2. Have you ever had any serious illness or operations? Yes No

If yes, please describe:_____

3. Have you ever had a blood transfusion? Yes No If yes, when?_____

4. WOMEN: Are you pregnant? Yes No Nursing? Yes No Taking Birth Control Pills? Yes No

5. Do you have or have you ever had any of the following? (Please check all that apply)

__A.I.D.S
__Anemia
__Arthritis, Rheumatism
__Artificial Joints
__Artificial Heart Valve
__Asthma
__Sickle Cell Disease
__Blood Disease
__Cancer/Tumor
__Chemical Dependency
__Circulation Problems
__Cortisone Treatments
__Diabetes
__Epilepsy
__Ulcer
__Eye Problems

__Fainting
__Headache
__Heart Murmur
__Heart Problems
__Hemophilia
__Hepatitis= Type:___
__High Blood Pressure
__HIV Positive
__Jaw Pain
__Kidney Disease
__Liver Disease
__Latex Sensitivity
__Metal Allergies (e.g:Nickel)
__Mitral Valve Prolapse
__Prolonged Bleeding
__Pacemaker

__Psychiatric Care
__Radiation Treatment
__Respiratory Disease
__Rheumatic Fever
__Seasonal Allergies
__Scarlet Fever
__Shortness of Breath
__Skin Rash
__Stroke
__Swollen Feet/Ankle
__Thyroid Problems
__Tobacco Habit
__Tonsillitis
__Tuberculosis
or +PPD Skin Test
__Venereal Disease

6. Do you have any disease or condition not listed above? Yes or No
If yes, please describe: _____

_____

7. Please list any medications you are currently taking or have taken within the last six months:
_____
_____
_____

8. Do you have any allergies to any drug or medication? Yes No If yes, please list:

_____