San Ramon
ENDODONTICS

Patient Name: _____ **SSN:** _____ **Sex: M F**

Address: _____ City_____ State_____ Zip_____

Home #: _____ Cell #:_____ Age: _____ DOB: _____ ☐ Married ☐ Single

Employer: _____ Address: _____ Work #:_____

Email: _____

Financial Responsible Person (if different from patient):_____Relationship:_____

DOB: _____ SSN:_____ Phone #:_____

General Dentist: _____ Referred By _____

Dental Insurance Information

Name of Subscriber: _____ DOB: _____ SSN:_____

Primary Insurance Company:_____ Phone #: _____

Employer: _____ Payor ID: _____

Subscriber ID#:_____ Group Number#: _____

I understand that I am responsible for all treatment received and also understand that if I have insurance, it will be filed as a courtesy to me. I also authorize my insurance to issue payment directly to San Ramon Endodontics.

Signature of Patient/Guardian: _____ Date: _____

Health History

Reason for your visit? _____

☐Yes ☐ No Are you Allergic to any medications? _____

Please list ALL medications you are taking at this time: _____

_____

Do you have or have you ever had any of the following:

Y / N Heart Disease	Y / N Glaucoma	Y / N Stomach Ulcers	**Females only**
Y / N Heart Attack	Y / N Diabetes	Y / N Kidney Problems	Y / N Are you pregnant?
Y / N Heart Murmur	Y / N Anemia	Y / N Cancer	Weeks? _____
Y / N High Blood Pressure	Y / N Bleeding Problems	Y / N Radiation/Chemo	Y / N Birth Control Pills
Y / N Rheumatic Fever	Y / N Systemic Lupus	Y / N Psychiatric Care	Y / N Breast Feeding
Y / N Mitral Valve Prolapse	Y / N Hepatitis	Y / N Fainting Tendency	
Y / N Shortness of Breath	Y / N Thyroid Disease	Y / N HIV/AIDS	
Y / N Chest Pains	Y / N Tuberculosis	Y / N Treatment w/Steroid	
Y / N Sinus Problems	Y / N Severe Headaches	Y / N Organ Transplant	
Y / N Lung Problem/Asthma	Y / N Seizures	Y / N Liver Problem/Jaundice	
Y / N Joint Replacement	Y / N **Takes Pre-Med**	Y / N **Latex/Rubber Allergy**	

List any other medical problems not mentioned above:_____

☐Yes ☐ No Are you currently under a physician's care for any medical condition? _____

Physician's Name: _____ Phone #: _____

☐Yes ☐No Have you been hospitalized within the past year? If yes, what was the reason?

_____

☐Yes ☐ No Are you taking bisphosphonates? (Osteoporosis Medication)

- **Acknowledgement of Receipt of the *HIPPA Notice of Privacy Policy* & *San Ramon Endodontics Financial Policy***

-I hereby acknowledge that I have read/requested a copy of the office *HIPPA Notice of Privacy Practice Policy*.

-I have been given the opportunity to ask questions regarding this policy. I give San Ramon Endodontics the permission to send my information to my Dentist/Specialist, Physician and/or my Insurance Company if it is requested.

-I have read/accept *San Ramon Endodontics Financial Policy* and understand that I am responsible for any unpaid balance.

Signature of Patient/Guardian: _____ Date: _____

Doctor's Signature: _____ Date: _____