CONFIDENTIAL

Leawood Commons Endodontics

11409 Ash St. Suite A, Leawood, KS 66211

913.491.5552

PERSONAL INFORMATION

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.

Driver's License: ______________

Patient's First: ____________________ M.I.: _____ Last: ____________________ Date of Birth: ________________

Address: __________________________________ City: ____________________ Zip Code: ____________________

Home Phone: ______________________________ Bus. Phone: ____

Employer:_________________________________ Cell Phone: ____

Emergency Contact Name and Number: ____

Who is your General Dentist? ____

Who Referred You? ____

INSURANCE INFORMATION

Primary Dental Ins. Holder: __________________ If minor, responsible party: ______________________________

Patient's First: ____________________ M.I.: _____ Last: ____________________ Holder D.O.B.: _________________

Address: __________________________________ City: ____________________ Zip Code:__________________

Home Phone: ______________________________ Bus. Phone: ____

Employer:_________________________________ Cell Phone: ____

Insurance Company: ____

Insurance Company Address: ____

Group No.: ________________________________ Insurance Phone: _____________________________________

Second. Dental Ins. Holder: _________________ If minor, responsible party: ___________________________

Patient's First: ____________________ M.I.: _____ Last: ____________________ Holder D.O.B.: _________________

Address: __________________________________ City: ____________________ Zip Code:__________________

Home Phone: ______________________________ Bus. Phone: ____

Employer:_________________________________ Cell Phone: ____

Insurance Company: ____

Insurance Company Address: ____

Group No.: ________________________________ Insurance Phone: _____________________________________

AUTHORIZATION AND RELEASE

Payment is expected when services are rendered. For your convenience, we will prepare insurance claims for you.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and / or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

The following information is routinely provided to anyone considering treatment in our office. Although good results are expected, the possibility and nature of complication cannot be accurately anticipated and therefore, there can be no guarantee as to the results of the treatment or as to cure. Although the likelihood of their occurrence in extremely remote, some risks are now to be associated with dental procedures. Some are postoperative discomfort, trismus (restrictive jaw opening), numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, and allergic reactions.

I have read the preceding risks that may occur in connection with this procedure. I believe I have been given and understand sufficient information to give consent to the above treatment, and to the administration of anesthetics and medications that the staff of Leawood Commons Endodontics deems necessary for the care of the patient named above.

Patient: ____________________________________ Date: ____

Legally Responsible Person: ____

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MEDICAL HISTORY – PLEASE PRINT

Date: ______________

Patient Name: ______________________________

Present Complaint: ______________________________

Is the present problem due to an accidental injury? . . . . Yes ❑ No ❑

How and when did the accident occur? ______________________________

In the following questions, answer YES or NO, whichever applies. Your answers are for our records only, and will be considered confidential.

Has there been a change in your general health in the past year? . . . . Yes ❑ No ❑

My last physical examination was on: ______________________________

Are you under the care of a physician? . . . . Yes ❑ No ❑

If so, what is the condition being treated? ______________________________

The name and city of my physician is: ______________________________

DO YOU HAVE OR HAVE YOU EVER HAD?

ADD / ADHD . . . . Yes ❑ No ❑
Anemia . . . . Yes ❑ No ❑
Asthma . . . . Yes ❑ No ❑
Arthritis . . . . Yes ❑ No ❑
Autism . . . . Yes ❑ No ❑
Diabetes . . . . Yes ❑ No ❑
Epilepsy . . . . Yes ❑ No ❑
Fainting Spells . . . . Yes ❑ No ❑
Hepatitis . . . . Yes ❑ No ❑
Immune Deficiency . . . . Yes ❑ No ❑
Inflammatory Rheumatism . . . . Yes ❑ No ❑
Kidney Trouble . . . . Yes ❑ No ❑
Liver Disease . . . . Yes ❑ No ❑
Joint Replacement . . . . Yes ❑ No ❑
Rheumatic Fever . . . . Yes ❑ No ❑
Sinus Condition . . . . Yes ❑ No ❑
Stomach Ulcers . . . . Yes ❑ No ❑
Thyroid . . . . Yes ❑ No ❑
Venereal Disease . . . . Yes ❑ No ❑
Cancer . . . . Yes ❑ No ❑

Other: ______________________________

Radiation Therapy . . . . Yes ❑ No ❑
Abnormal Heart Condition . . . . Yes ❑ No ❑
Heart Surgery . . . . Yes ❑ No ❑
Heart Valve Replacement . . . . Yes ❑ No ❑
Chest Pain . . . . Yes ❑ No ❑
Heart Attack . . . . Yes ❑ No ❑
Coronary Insufficiency . . . . Yes ❑ No ❑
Pacemaker . . . . Yes ❑ No ❑
Stroke . . . . Yes ❑ No ❑
Angina . . . . Yes ❑ No ❑

Blood Pressure:
High: ________ Low: ________ Normal: ________

Hemophilia . . . . Yes ❑ No ❑

Abnormal Bleeding From:
a Cut ________ an Extraction ________

Are you taking blood thinners . . . . Yes ❑ No ❑
Women: Are you pregnant? . . . . Yes ❑ No ❑
Are you taking Birth Control Pills? . . . Yes ❑ No ❑
Are you Breast Feeding? . . . . Yes ❑ No ❑

Have you ever had any serious trouble associated with any previous dental treatment? . . . . Yes ❑ No ❑

Explain when: ______________________________

Do you have any disease, condition, or problem not listed that you think I should know about? . . . . Yes ❑ No ❑

If so, explain why: ______________________________

Are you taking any of the following?

Antibiotics or sulfa drugs . . . . Yes ❑ No ❑
Anticoagulants (blood thinners) . . . . Yes ❑ No ❑
Medicine for high blood pressure . . . . Yes ❑ No ❑
Cortisone (steroids) . . . . Yes ❑ No ❑
Tranquilizers . . . . Yes ❑ No ❑
Aspirin . . . . Yes ❑ No ❑
Insulin, tolbutamide (orinase) or similar drug . . Yes ❑ No ❑
Digitalis or drugs for heart trouble . . . . Yes ❑ No ❑
Nitroglycerin . . . . Yes ❑ No ❑
Oral Contraceptives . . . . Yes ❑ No ❑
Suboxone . . . . Yes ❑ No ❑

Are you allergic or have you reacted adversely to:

Latex . . . . Yes ❑ No ❑
Local anesthetics (i.e. Epinephrine) . . . . Yes ❑ No ❑
Penicillin . . . . Yes ❑ No ❑
Tetracycline . . . . Yes ❑ No ❑
Other antibiotics (list below) . . . . Yes ❑ No ❑
Barbiturates, sedatives, or sleeping pills . . . . . Yes ❑ No ❑
Aspirin . . . . Yes ❑ No ❑

Other: ______________________________
____
____

Have you ever had an addiction or problem with alcohol or other drugs? . . . . Yes ❑ No ❑

Names of medications: ______________________________

The above information that I have provided is true and correct to the best of my knowledge.

X ______________________________
Signature of Patient or Legally Responsible Party