PATIENT HISTORY & INFORMATION (please print)

Name_____ Sex M F Marital Status _____ Birthdate _____
(first) (middle) (last)

Address_____ City_____ State_____ Zip _____

Occupation_____ SSN _____ Home # _____ Cell #_____

Employer/School _____ Work # _____ E-mail _____

Employer/ School Address_____ City_____ State_____ Zip _____

In case of emergency _____ Home # _____ Cell #_____

Who Referred You to Us? _____ Who is your General Dentist? _____

SPOUSE / PARENT INFORMATION

Name_____ Relationship_____ Tel # _____

Address_____ City_____ State_____ Zip _____

Occupation_____ SSN _____ Home # _____ Cell # _____

Employer _____ Work # _____ E-mail _____

Employer Address_____ City_____ State_____ Zip _____

PRIMARY DENTAL INSURANCE

Name of Subscriber: _____Subscriber Birthdate _____

Name of Insurance Company: _____ Subscriber ID # _____

SECONDARY DENTAL INSURANCE

Name of Subscriber: _____Subscriber Birthdate _____

Name of Insurance Company: _____ Subscriber ID # _____

ESV
ENDODONTICS
OF SILICON VALLEY
456B E. Calaveras Blvd., Milpitas, CA, 95035

1. Is your general health good? ..... **Yes** **No**
   If **NO**, please explain _____
   _____

2. What medications including herbs, vitamins and diet pills are you taking at the present time
   _____
   _____

3. Do you have any allergies to or are you sensitive to latex or any drugs such as penicillin ... **Yes** **No**
   If yes, please list them here _____
   _____

4. Are you subject to fainting, dizziness, nervous disorders, convulsions or epilepsy..... **Yes** **No**

5. Have you ever had any breathing difficulty such as asthma, emphysema, chronic cough, pneumonia, tuberculosis or any other lung disorders ..... **Yes** **No**

6. Have you been advised by your **Physician** or **Cardiologist** to take antibiotics prior to **All** dental treatment, including routine dental cleanings. ..... **Yes** **No**

7. Have you ever taken the diet drug Phen-Phen? Also known as Redux or Pondimen..... **Yes** **No**

8. Have you ever taken a drug used to treat some cancers and osteoporosis known as a bisphosphonate? Some names are: Fosamax, Actonel, Boniva, Zoneta, Bonefos, Aredia....**Yes** **No**

9. Have you ever experienced any of the following:
   Anemia..... **Yes** **No**
   Alcohol / Drug Abuse .....**Yes** **No**
   Bleeding Problems..... **Yes** **No**
   Bruise Easily .....**Yes** **No**
   Chest Pains (angina) / Shortness of Breath .....**Yes** **No**
   Diabetes..... **Yes** **No**
   Hepatitis.....Type_____..... **Yes** **No**
   Heart Problems..... **Yes** **No**
   High or Low Blood Pressure..... **Yes** **No**
   Kidney Disease..... **Yes** **No**
   Prosthetic Heart Valve / Prosthetic Joint i.e.Artificial Hip..... **Yes** **No**
   Radiation Therapy / Chemotherapy..... **Yes** **No**
   Rheumatic Fever / Heart defect / Heart Murmur..... **Yes** **No**
   Sexually Transmitted Disease..... **Yes** **No**
   Sinus Problems.....**Yes** **No**
   Stroke..... **Yes** **No**
   Surgeries / Hospitalization ..... **Yes** **No**

10. Do you have a condition or problem not listed you feel we should know about..... **Yes** **No**
    If **YES**, briefly explain here_____
    _____

Women Only:

11. Are you or could you be pregnant? Which month_____ Due Date_____ ..... **Yes** **No**

12. Are you breastfeeding.....**Yes** **No**

13. Are you taking birth control..... **Yes** **No**

My signature below indicates I have received a copy of this offices Notice of Privacy Practices.....

Signature _____ Date_____

UPDATE:
Signature _____ Date_____