RIDGE MEADOWS
ENDODONTICS

First Name:	Last Name:
Home Phone:	Cell Phone:
Work Phone:	
Date of Birth:	Gender:
Home Address:	
City:	Province:
Postal Code:	Referring Dentist:
Email Address:	
Spouse/Guarantor or Emergency Contact: (name) Circle relationship to you as well	
Phone Number:	

	Yes	No	Don't know
1. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If yes, please explain.			
2. Has there been any change in your general health within the past year? If yes, please explain.			
3. Are you under the care of a physician for a current problem? If yes, explain.			
4. Have you been hospitalized within the past 5 years? Please specify.			
5. Are you taking any medication or drugs? Please list them below.			
6. Have you received therapy for alcoholism or drug addiction in the past 5 years?			
7. Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetics/antibiotics/ medications?			
8. Is there any condition concerning your health that the doctor should be told?			
9. Do you wish to speak to the doctor privately about anything?			
10. Have you had abnormal bleeding with previous extractions, surgery, or trauma?			
11. Have you ever required a blood transfusion?			
12. Have you ever had surgery and/or radiation for a tumor, growth, or other condition?			
13. Have you ever tested positive for HIV infection or AIDS? If so, state date diagnosed and treating doctor.			
14. Are you required to take antibiotics prior to dental treatment?			

Do you have or have you had any of the following?

- ☐ High blood pressure
- ☐ Heart murmur or prolapsed valve
- ☐ Joint prosthesis (hip, knee, etc.)
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Congenital heart disease
- ☐ Cardiovascular disease: heart attack, stroke/ bypass
- ☐ Prosthetic heart valve
- ☐ Blood disorder (e.g. anemia)
- ☐ Sinus trouble
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Stomach ulcers, colitis
- ☐ Hepatitis, jaundice, liver disease
- ☐ Psychiatric treatment
- ☐ Fainting spells or seizures
- ☐ Epilepsy

☐	Venereal disease	☐	Cancer
☐	Asthma	☐	Tempro mandibular joint problems (TMJ)
☐	Allergy to latex	☐	Low blood sugar
☐	Low blood pressure	☐	Dialysis
☐	Chest pain, angina	☐	Irregular heartbeat
☐	Swollen ankles, arthritis or joint disease	☐	Contagious diseases
☐	Cardiac pacemaker	☐	Bronchitis, chronic cough
☐	Heart surgery	☐	Hay fever or sinus problems
☐	Delay in healing	☐	Problems with the immune system
☐	Tuberculosis	☐	Difficult breathing or other lung trouble
☐	Emphysema	☐	Chronic fatigue or night sweats
☐	X-Ray treatment or chemotherapy	☐	History of drug abuse
☐	On a diet	☐	Wear contact lenses
☐	History of alcohol abuse	☐	Bruise easily
☐	Eye disease or glaucoma	☐	Gallbladder trouble
☐	Infectious mononucleosis	☐	None of the above

	Yes	No	Don't Know
15. Do you have any disease, condition or problem not listed above? Specify.			

Possibility of pregnancy:	YES / NO	Taking birth control pills:	YES / NO

Injury:

This visit is related to an accident	YES / NO	Work related:	YES / NO
Date of injury:			
Claim Number:			

OFFICE FINANCIAL POLICY *(please read before signing)*

If we only provide Endodontic Evaluation (Limited Evaluation, Consultation):

This consists of an examination and testing, discussing the likelihood of maintaining the tooth and treatment options available to you. Payment is due at the time of service. A standard dental claim form will be submitted to your insurance for reimbursement payable directly to you.
If we provide Treatment:

Those without dental insurance: All fees will be required when treatment is rendered.

Those with dental insurance: As a courtesy to you, we may agree to accept assignment of dental benefits from some insurance companies. **YOUR INSURANCE WILL NOT PAY FOR ALL OUR FEES.** We will estimate the portion your insurance is likely to pay. Since this varies for each individual your estimated portion is due at the time of service. Please keep in mind however, insurance companies routinely indicate that coverage verification does **NOT** guarantee payment.

If we do not accept assignment (direct billing) to your insurance, a standard dental claim form will be submitted to your insurance for reimbursement.

If your insurance company pays **more** than the estimated amount, a refund will be processed by our office.
If your insurance company pays l**ess** than than the estimated amount, you will receive a statement from our office.

_____ _____

Patient Signature (Parent signature if patient is under 18 years of age). Date