WICHITA FALLS ENDODONTICS

Ben Baker, D.D.S., M.S.
1804 Brook Avenue
Wichita Falls, TX 76301
Phone: 940-247-0286
Fax: 940-228-4148
info@WichitaFallsEndo.com
www.WichitaFallsEndo.com

PATIENT INFORMATION & HEALTH HISTORY

Date _____

Name (First, Middle, Last) _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Business Phone _____
Cell Phone _____ Email Address _____
Social Security Number _____ Birth Date _____
Sex _____ Marital Status _____
Employer _____ Present Position _____
Address _____ City _____ State _____
Spouse name _____
Please enter name, phone number and relationship of person(s) to be contacted in case of emergency

_____

Name of dental provider: _____
Preferred Pharmacy: _____

INSURANCE INFORMATION

Dental Insurance Co Name _____ Group Number _____
Dental Insurance Co Phone _____ Effective Date _____
Dental Insurance Co Address _____
Primary Insured – Name _____
Primary Insured – Birthdate _____
Member/Subscriber ID _____
Primary Insured SSN _____

MEDICAL INFORMATION

Name of physician: _____

Your current physical health is ☐GOOD ☐FAIR ☐POOR
Are you currently under the care of any physician? ☐YES ☐NO
If yes, please explain _____
Do you smoke or use tobacco in any form? ☐YES ☐NO
Are you presently taking any drugs prescribed by a physician or dentist? ☐YES ☐NO
If yes, please list _____
For women, are you pregnant? ☐YES, Week # _____ ☐NO
Have you ever been premedicated before dental treatment? ☐YES ☐NO

Have you been hospitalized within the last 5 years? ☐YES ☐NO
If yes, please explain _____
Have you had any serious medical problems in the last 5 years? ☐YES ☐NO
If yes, please explain _____

Have you ever had any of the following diseases or medical problems?

☐YES ☐NO Heart Attack/Stroke
☐YES ☐NO Heart Murmur
☐YES ☐NO Mitral Valve Prolapse
☐YES ☐NO High Blood Pressure
☐YES ☐NO Low Blood Pressure
☐YES ☐NO Heart Surgery/Pacemaker
☐YES ☐NO Congenital Heart Defect
☐YES ☐NO Blood Transfusion
☐YES ☐NO HIV+/AIDS
☐YES ☐NO Hepatitis
☐YES ☐NO Hemophilia/Abnormal Bleeding
☐YES ☐NO Anemia
☐YES ☐NO Arthritis
☐YES ☐NO Artificial Bones/ Joints
☐YES ☐NO Cancer/Chemotherapy
☐YES ☐NO Radiation Treatment

☐YES ☐NO Psychiatric Problems
☐YES ☐NO Epilepsy or Seizures
☐YES ☐NO Fever Blisters
☐YES ☐NO Diabetes
☐YES ☐NO Drug/Alcohol Abuse
☐YES ☐NO Venereal Disease
☐YES ☐NO Kidney/Liver Problems
☐YES ☐NO Ulcers/Colitis
☐YES ☐NO Fainting
☐YES ☐NO Sinus Problems
☐YES ☐NO Asthma
☐YES ☐NO Glaucoma
☐YES ☐NO Emphysema
☐YES ☐NO Rheumatic Fever
☐YES ☐NO Tuberculosis (TB)
☐YES ☐NO Shingles

Have you experienced any other medical problems that are not listed above? ☐YES ☐NO
If yes, please list _____

Are you allergic to any of the following drugs?

☐YES ☐NO Penicillin
☐YES ☐NO Erythromycin
☐YES ☐NO Dental Anesthetics
☐YES ☐NO Latex

☐YES ☐NO Aspirin
☐YES ☐NO Tetracycline
☐YES ☐NO Codeine
☐YES ☐NO Sulfa

Are you allergic to any other drugs? ☐YES ☐NO If yes, please list _____

ACKNOWLEDGEMENT AND AUTHORITY

I hereby authorize payment of my dental benefits directly to the office of Wichita Falls Endodontics. I also acknowledge full responsibility for the payment of such services and agree to pay for them in full at the time of service.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Wichita Falls Endodontics of any changes in my medical status.

Signed_____ Date_____
Patient or Parent/Guardian of Minor