Lee and Murrin Endodontics

Confidential Medical & Personal History

Please Print

Patient Name ❑ Ms. ❑ Mrs. ❑ Mr. ❑ Dr. _____ Birthday ____ / ____ / ____

How would you like to be addressed? _____

Person Responsible for Account _____

Home Address _____ Home Phone _____

City / State / Zip _____ Cell Phone _____

Employer _____ Business Phone _____

Employer Address _____

City / State / Zip _____

Who Referred You to this Office? _____

Family Dentist _____ Patient's SS# _____

PRIMARY DENTAL INSURANCE

Subscriber Name _____

Subscriber's SS# or ID# _____ Date of Birth _____

Subscriber's Employer _____ Group# _____

Name & Address of Primary Dental Insurance Co. _____

_____

_____

SECONDARY DENTAL INSURANCE

Subscriber Name _____

Subscriber's SS# or ID# _____ Date of Birth _____

Subscriber's Employer _____ Group# _____

Name & Address of Secondary Dental Insurance Co. _____

_____

_____

AUTHORIZATION FOR INFORMATION AND INSURANCE RELEASE

I authorize release of information to my family dentist and to my insurance company(s) in order to process my insurance claim. I understand that I am responsible for all costs of my dental treatment. I understand that this endodontic specialty practice is a participating provider with Delta Dental Premier and no other insurance plans and that I am responsible for knowing the terms of my own insurance coverage. If fees are not paid in full by me at the time of service, I hereby authorize payment of dental benefits from insurance, otherwise payable to me, directly to James R. Murrin, DDS, MS, Inc.

_____ ____ / ____ / ____

Signed (Employee or Spouse, Parent if minor) Date

- See page 2 for Patient Information -

Have you had, or do you presently have any of the following conditions?

	Yes	No		Yes	No
Heart Attack - Date _____	❍	❍	Jaw Joint (TMJ) Problems	❍	❍
Stroke - Date _____	❍	❍	Ulcers	❍	❍
Heart Surgery - Date _____	❍	❍	Colitis or Irritable Bowel Syndrome	❍	❍
Heart Disease	❍	❍	Surgery or x-ray treatment for a tumor, growth,		
Aortic Stenosis	❍	❍	or other condition of the head, mouth, or lips	❍	❍
Bacterial Endocarditis	❍	❍	AIDS or HIV Positive	❍	❍
Artificial Vascular Graft	❍	❍	Hepatitis, Jaundice, or Liver Disease	❍	❍
Chest Pain/Angina Pectoris	❍	❍	Blood Transfusion	❍	❍
High/Low Blood Pressure	❍	❍	Drug Addiction/Alcoholism	❍	❍
Heart Murmur	❍	❍	Hemophilia or Excessive Bleeding	❍	❍
Rheumatic Fever/Rheumatic Heart Disease	❍	❍	Cold Sores/Herpes	❍	❍
Congenital Heart Lesions/Mitral Valve Prolapse	❍	❍	Glaucoma	❍	❍
Artificial Heart Valve - Date _____	❍	❍	Depression/Psychiatric Treatment	❍	❍
Heart Pacemaker	❍	❍	Allergies/Hay Fever	❍	❍
Joint Replacement - Site _____ Date _____	❍	❍	Asthma	❍	❍
Kidney Disease	❍	❍	Sinus Trouble	❍	❍
Cancer or Tumors	❍	❍	Seizures/Epilepsy	❍	❍
Thyroid Disease	❍	❍	Arthritis	❍	❍
Lung Disease/Tuberculosis	❍	❍	Phen-Fen or Redux Diet	❍	❍
Diabetes	❍	❍			

Are you currently taking or have you previously taken bisphoshonate medications, such as Actonel, Boniva, Evista, Fosamax, or Zometa? ❍ Yes ❍ No

Are you currently taking prescription blood thinner (Coumadin or Warfarin)? Most recent INR value_____date_____.

Are you currently a smoker or using tobacco products? ❍ Yes ❍ No

Have you ever had an allergic or unusual reaction to any of the following?

	Yes	No		Yes	No
Local Anesthetics ("Novocaine")	❍	❍	Penicillin or Amoxicillin	❍	❍
Ibuprofen or Advil	❍	❍	Clindamycin or Other Antibiotics	❍	❍
Acetaminophen (Tylenol)	❍	❍	Triazolam, Halcion or Valium	❍	❍
Barbiturates/Tranquilizers (Sleeping Pills)	❍	❍	Iodine	❍	❍
Codeine or Other Narcotics	❍	❍	Any Other Medication or Drugs	❍	❍
Latex/Rubber Materials	❍	❍	Which Ones? _____		
			_____		

Women:

	Yes	No	
Are You Pregnant?	❍	❍	If Yes, How Many Months? _____
Do You Anticipate Becoming Pregnant?	❍	❍	
Are You Breast Feeding?	❍	❍	

Please list any medications and/or recreational drugs (over the counter, prescription, or herbal/alternative) that you are taking now:

_____

_____

_____

_____

If you have had any serious complications involving dental treatment, please explain:

_____

_____

Informed Consent: I understand that root canal treatment is a procedure to retain a tooth which may otherwise require extraction. Occasionally, a patient may experience post-operative discomfort or swelling which may require medication for several days. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery, or even extraction.

_____ _____

Patient (or Guardian) Signature **Date**

_____

Updates