

1550 S. Highland Avenue, Ste A

Clearwater, FL 33756

727-443-3231

Rodney L. Anthony, DMD, PA

Christopher L. Ross, DMD, MS

Practice Limited to Endodontics

**PATIENT INFORMATION**

Last Name First Name □ Mr □ Mrs □Dr

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Home Cell Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS# Birthdate Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

General Dentist Referred by(if different) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Physician Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Insurance Subscriber Name DOB \_\_\_\_\_\_\_\_\_\_\_

Subscriber ID Group ID Phone \_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Relationship Phone \_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

 Yes No

Are you now, or have you been within the past 2 years, under the care of a physician? [ ]  [ ]

Have you ever been hospitalized or had major surgery? [ ]  [ ]

Are you pregnant? Nursing? [ ]  [ ]

Do you need to pre-medicate with antibiotics prior to dental treatment? [ ]  [ ]

Have you experienced an unfavorable reaction to previous dental treatment? [ ]  [ ]

Please list all medications you are currently taking:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (while on birth control medication you must use additional methods when taking antibiotics and for 72 hours afterward)

|  |  |  |  |
| --- | --- | --- | --- |
|[ ]  MITRAL VALVE PROLAPSE |[ ]  HEPATITIS OR JAUNDICE |[ ]  DIABETES |[ ]  HEART MURMER |
|[ ]  LIVER PROBLEMS |[ ]  ASTHMA/BREATHING ISSUES |[ ]  ENDOCARDITIS |[ ]  ULCERS |
|[ ]  HEART VALVE REPLACEMENT |[ ]  HEART PROBLEMS |[ ]  LUNG DISORDER |[ ]  KIDNEY DISEASE |
|[ ]  RHEUMATIC FEVER |[ ]  VENEREAL DISEASE |[ ]  THYROID DISORDER |[ ]  TUBERCULOSIS |
|[ ]  HIV/AIDS |[ ]  CANCER |[ ]  PACEMAKER |[ ]  HERPES  |
|[ ]  GLAUCOMA |[ ]  STROKE |[ ]  EPILEPSY |[ ]  NERVOUS DISORDER |
|[ ]  HIGH BLOOD PRESSURE |[ ]  BLOOD DISORDER |[ ]  DIZZINESS/FAINTING |[ ]  ARTIFICIAL JOINT |
|[ ]  BLOOD TRANSFUSION |[ ]  RADIATION THERAPY |[ ]  CHEMOTHERAPY |[ ]  DRUG ADDICTION |
|  |  |  |  |  |  |  |  |

 Check any of the following you have had or currently have:

[ ] OTHER:

ALLERGIES: [ ] Penicillin/Other Antibiotics [ ] Codeine/Other Pain Meds [ ] Xylocaine/Other Dental Anesthetics

 [ ] OTHER:

Signature: Date: \_\_\_\_\_\_\_\_\_\_\_\_

 Patient, Parent or Guardian