

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