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Rodney L. Anthony, DMD, PA
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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)

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

☐ 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

☐OTHER:_____

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

☐OTHER:_____

Signature: _____ Date: _____
Patient, Parent or Guardian