Purcellville Endodontics
609 East Main Street Suite P Purcellville, VA 20132
(P) 540.900.0970 (F) 540.767.5227 Email: info@purcellvilleendo.com

Patient Information:

Please Circle: Ms. Mr. Mrs. Dr. Other: _____

First Name _____ Last Name _____ M.I. _____ Name Preference _____

Address _____ City _____ State _____ Zip _____

Cell # _____ Home # _____ Email _____

Date of Birth _____ Gender _____ SSN # _____ Occupation _____

Employer Name _____ Employer Address _____

Emergency Contact Name _____ Cell # _____ Relationship _____

Dental Insurance Information:

Insurance Company _____ Insurance Phone # (Usually found on the back of card) _____

Claims Address _____

Subscriber Name _____ ☐check if same as patient Subscriber Social Security/ID # _____ Date of Birth _____

Group Number _____ Group Name _____

Secondary Dental Insurance (If applicable): Ins Company: _____

Insurance Phone # _____ Subscriber Name _____ ☐ check if same as patient

Subscriber Social Security/ID # _____ Date of Birth _____ Group Number _____

Signature: _____ ***Date:** _____

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Health information:

_____ _____

General Dentist/Referring Dentist Phone #

_____ _____

Family Physician Date of Last Physical Exam

Do you have or have you had any of the following?

□Artificial Heart Valve	□Heart Surgery	□High Blood Pressure	□Hepatitis A/B	□Stomach Ulcers
□Congenital Heart Disease	□Heart Pacemaker	□ Diabetes	□HIV/AIDS	□Bleeding Disorder
□Infective Endocarditis	□Heart Attack	□ Thyroid Disorder	□Tuberculosis	□ Jaw/TMJ
□Knee/Hip Replacement	□Heart Murmur	□ Asthma	□Dialysis	□ Epilepsy

Any major surgeries/operations? □ Yes □ No

If so, please describe: _____

_____

Any **other** diseases or issues? □ Yes □ No

_____

_____

Have you ever taken Bisphosphonates? _____

(Fosamax, Aredia, Zometa, Actonel, Boniva, Skelid, Didronel, Bonefos Ostec)

Have you had an unusual reaction/allergy to **LATEX, ANESTHETICS,** or drugs as **PENICILLIN, CLINDAMYCIN, NOVOCAINE, IBUPROFEN, ASPIRIN** or any other medications?

_____

Have you taken **Aspirin, Ibuprofen** or **Tylenol** in the last 24 hours? □Yes □ No

Please list any medications you are taking at present and the reason for each:

_____

_____

_____

_____

For Women:

Pregnant or Possible Pregnancy? □ Yes □ No **Are you nursing?** □ Yes □ No **Taking birth control?** □Yes □No

Signature: _____ **Date:** _____