PERSONAL INFORMATION

John Gilbreth, DDS, MS
practice exclusive to endodontics

Today's Date:

Contact Information

Name: Last First Middle

Home Phone: Include area code ( )

Business/Cell Phone: Include area code ( )

Address:

City:

State:

Zip:

Email:

Date of birth:

Sex: M F

Social Security #:

Emergency Contact:

Relationship:

Phone:

Occupation:

Name of Referring Dentist:

Dental Insurance Information

PRIMARY Insurance Company Name:

Patient's Relationshiip to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Employee/ Subsciber Name:

Subsciber Social Security Number:

Subsciber Date of Birth:

Name of Employer:

Group Number:

SECONDARY Insurance Company Name:

Patient's Relationshiip to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Employee/ Subsciber Name:

Subsciber Social Security Number:

Subsciber Date of Birth:

Name of Employer:

Group Number:

Release and Authorization

I authorize release of any information relating to this claim. I understand I am responsible for all costs of dental treatment.

Signature:

I hereby authorize payment of the dental benefits otherwise payable to me directly to the dental entity John Gilbreth DDS, MS.

Signature:

MEDICAL INFORMATION

John Gilbreth, DDS, MS
practice exclusive to endodontics

Dental Information

	Yes	No	DK
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Do you have earaches or neck pains?	☐	☐	☐

	Yes	No	DK
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐
Do you have anxiety when visiting the dentist ?	☐	☐	☐
Do you have anxiety when visiting the dentist?	☐	☐	☐

Do you have any particular concerns you would like your dentist to know about?

Medical Information

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name:

Phone:

Are you taking either of the medications alendronate (Fosamax) or risedronate (Actonel)?	☐	☐	☐
If yes, do you receive intravenous bisphosphonate treatment?	☐	☐	☐
Have you had an orthopedic total joint replacement?	☐	☐	☐

Height:

Weight:

	Yes	No	DK
Has there been any change in your general health within the past year?	☐	☐	☐
If yes, what condition is being treated?			
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐
If yes, what was the illness or problem?			
Do you use tobacco (smoking, snuff, chew)?	☐	☐	☐
Do you use recreational drugs?	☐	☐	☐

Allergies

	Yes	No	DK
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Codeine ro other narcotics	☐	☐	☐
Latex (rubber)	☐	☐	☐
Hay fever/seasonal allergies	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐

Medications

	Yes	No	DK
Antibiotic	☐	☐	☐
Pain Medicine	☐	☐	☐
Asthma Medication	☐	☐	☐
Aspirin	☐	☐	☐
Bisohosphonates	☐	☐	☐
Blood Thinners	☐	☐	☐
Blood Pressure	☐	☐	☐
Cortisone/Steriods	☐	☐	☐

	Yes	No	DK
Epilepsy	☐	☐	☐
Insulin	☐	☐	☐
Thyroid	☐	☐	☐
Diet Medications	☐	☐	☐
Herbal Medicine	☐	☐	☐
Birth Control Pills	☐	☐	☐
Other	☐	☐	☐

Specify:_____

Medical Conditions

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)	☐	☐	☐
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Heart attack	☐	☐	☐
High/Low blood pressure	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐

	Yes	No	DK
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
COPD	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Sexually transmitted disease	☐	☐	☐

	Yes	No	DK
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify:_____			
Mental health disorders	☐	☐	☐
Specify:_____			
Recurrent infection:	☐	☐	☐
type of infection:_____			
Kidney problems	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/migraines	☐	☐	☐
Pregnant/Breastfeeding	☐	☐	☐

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me.

Signature of Patient/Legal Guardian:

Date: