GRAND TRAVERSE
ENDODONTICS
Specialists in Root Canal Therapy

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Last Name First Name Initial | Birth Date | Social Security Number | Home Phone

Gender: ☐ Male ☐ Female Please check one: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Address | Apt. No. | City & State | ZIP Code

Patient's Employer | Occupation | Business Phone | Mobile Phone

Name of Spouse/Parent | Spouse/Parent Employer | Business Phone

Family Dentist | Referred by:

Chief Dental Complaint:

Primary Dental Insurance Company

Name: _____
Address: _____
Phone: _____
Group #: _____
Subscriber ID #: _____
Relation: _____

Secondary Dental Insurance Company

Name: _____
Address: _____
Phone: _____
Group #: _____
Subscriber ID #: _____
Relation: _____

Medical History

1. What is your estimation of you general health?
   ☐ Poor ☐ Fair ☐Good ☐ Excellent
2. Are you presently under a physicians care? ☐ Yes ☐ No
   Physicians name: _____
3. Date of last physical exam: _____
4. Have you been hospitalized in the past 5 years?
   ☐ Yes ☐ No
5. If so, for what reason: _____
6. Do you have or have ever had:
   - ☐ Diabetes
   - ☐ Epilepsy
   - ☐ Hepatitis
   - ☐ Endocarditis
   - ☐ Artificial Heart Valve
   - ☐ Abnormal Heart condition
   - ☐ Prolonged Bleeding
   - ☐ High/Low Blood Pressure
   - ☐ Tuberculosis
   - ☐ Coumadin/Blood Thinner
   - ☐ HIV/AIDS
   - ☐ Radiation or Chemo Therapy
   - ☐ Asthma
   - ☐ Artificial Joint Replacement
   - ☐ Drug/Alcohol Addiction
   - ☐ **Allergies To:**
     - ☐ **Penicillin**
     - ☐ **Tetracycline**
     - ☐ **Latex**
     - ☐ **Other** _____
7. Have you been advised to take an antibiotic before all dental appointments? ☐ Yes ☐ No
8. Do you take bone density medications? *(please circle)*
   Actonel / Boniva / Didionel / Fosamax / Skelid
   Donefoe / Zometa / Reclast / Other
   _____
9. (Women) Are you pregnant? ☐ Yes ☐ No
   If yes, how many months? _____
10. **Please list any prescribed medications you take:**
    _____
    _____
    _____

Medical History Updates

Date	Changes	Intials

Authorization: I certify that the answers to the health questions are correct to the best of my knowledge.
I hereby authorize payment of all dental insurance benefits directly to Grand Traverse Endodontics.
I understand that I am responsible for the total balance of my account, regardless of what my dental insurance may or may not cover.

I authorize Grand Traverse Endodontics to perform treatment on me or my minor child.
I have had the opportunity to review the Privace Notice for Grand Traverse Endodontics.

Authorized Signature X _____ **Date** _____