James D. Beller, D.D.S.

A Professional Corporation
Practice Limited to Endodontics

Name of Patient_____ _____ _____
(Mr Ms Miss Mrs Dr) (first name) (middle name) (last name)
☐ ☐ ☐ ☐ ☐
Home Address_____Unit#_____

_____ _____Birth Date:_____Age:_____
(city) (zip code)

Have you or any member of your family previously been a patient in our office? Yes No

Home Phone_____Work Phone_____Ext___

Cell Phone_____Pager#_____

Drivers License #:_____Social Security #:_____

Marital Status: Single___Married____Separated___Divorced___Widow___Domestic Partner___

Employed By_____Occupation_____

Business Address_____#_____City_____Zip_____

Name of Spouse_____ _____ _____
(Mr Ms Miss Mrs Dr) (first name) (middle name) (last name)
☐ ☐ ☐ ☐ ☐
Social Security #_____BirthDate_____Age_____

Home Phone_____Business Phone_____Ext_____

Cell Phone_____Pager #_____

Employed By_____Occupation_____

Business Address_____#_____City_____Zip_____

Emergency Contact_____Phone_____

Name of Referring Dentist_____# of years in this practice_____
Do you have Dental Insurance?_____Primary Carrier_____

I understand that root canal treatment is an attempt to retain a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery or even extraction.

Upon completion of root canal therapy in this office, I am to return to my general dentist for permanent restoration such as a crown, cap, jacket, onlay or filling.

I understand that the total payment of the fee for dental services by Dr. James D. Beller is my responsibility and not that of the insurance company. As a courtesy, insurance forms will be completed without charge. All payments and co-payments are due prior to treatment.

Date_____ Signature of Patient_____

Health History

The information on this page is confidential

Are you in good health?……Yes No
Are you allergic to penicillin, codeine, epinephrine, novocaine or other drugs?……Yes No
If the answer is yes please list the medications you are allergic to:_____

Do you have a **heart murmur, mitral valve prolapse, or artificial joints ?** Yes No

- Does your physician require you to pre-medicate? Yes No
- If yes, what did you pre-medicate with?_____

Please circle if you have a history of any of the following:

☐Heart (surgery, attack, disease)	☐Arthritis/Rheumatism	☐Glaucoma
☐Chest Pain	☐Nervous/Anxiety	☐Emphysema
☐Congenital Heart Disease	☐Swollen Ankles	☐Chronic Cough
☐Heart Murmur	☐Stroke	☐Tuberculosis
☐High Blood Pressure	☐Artificial Joints	☐Asthma
☐Mitral Valve Prolapse	☐Kidney Trouble	☐Allergies or Hives
☐Artificial Heart Valve	☐Ulcers	☐Cancer
☐Heart Pacemaker	☐Diabetes	☐Radiation Therapy
☐Rheumatic Fever	☐Thyroid Problems	☐Chemotherapy
☐Hepatitis A or B or C	☐Venereal Disease	☐Tumors
☐HIV Positive	☐Cold Sores	☐Latex Sensitivity
☐Blood Transfusion	☐Hemophilia	☐Fever Blisters
☐Sickle Cell Anemia	☐Bruise Easily	☐Liver Disease
☐Neurological Disorders	☐Epilepsy/Seizures	☐Fainting or Dizzy Spells

Do you or have you had any disease, condition or problem not listed?……Yes No
If yes please explain:_____

Are you taking any medications, including regular doses of aspirin, at present?……Yes No

Name of medications?……

What condition is being treated?……

Are you taking or have you taken biophosphonates?.....Yes No
(These include Fosamax, Boniva, Zoneta, Actonel, etc.)

Women: Are you pregnant? Yes No (Months) __ Nursing? Yes No

Are you taking birth control pills? Yes No

Name of Family Physician:_____Phone:_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency to release such information to you. I will notify Dr. Beller of any changes in my health or medication.

I give permission for my protected health information to be disclosed to my **spouse** and the people listed below:

Names: _____

Patient Signature_____Date_____

Print Form