LONESTAR ENDODONTIC ASSOCIATES, P.L.L.C.

(PLEASE PRINT)

DATE: _____

NAME:_____ DOB _____
LAST FIRST MIDDLE

ADDRESS:_____
CITY:_____ _____ STATE:_____ZIP_____
EMPLOYER: _____ WORK PHONE: _____
OCCUPATION_____ S.S.#_____ _____
HOME PHONE_____ CELL PHONE_____
EMAIL: _____
REFERRED BY:_____

IN CASE OF EMERGENCY NOTIFY:

1. NAME:_____PHONE:_____
2. NAME:_____PHONE:_____

PERSON RESPONSIBLE FOR ACCOUNT PAYMENT IF OTHER THAN PATIENT

NAME:_____S.S.#: _____
LAST FIRST MIDDLE

RELATIONSHIP TO PATIENT:_____HOME PHONE: _____
ADDRESS IF DIFFERENT: _____
CITY:_____STATE:_____ZIP: _____
EMPLOYER:_____WORK PHONE: _____

I,_____ hereby authorize the office of Lonestar Endodontic Associates to discuss my treatment and financial
(your name)
information with_____(for example a friend , spouse or relative).

I understand that by signing this release form I am complying with HIPAA Privacy Laws. The person(s) I listed above has my permission to discuss my personal dental information.

Sign: _____

AUTHORIZATION AND MEDICAL RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners.
I authorize and request my insurance company to pay directly to the dentist or dental group, insurance benefits otherwise payable to me. I understand that my
dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my
dependents.

X_____
Signature of patient (or parent/guardian if minor)

LONESTAR ENDODONTIC ASSOCIATES, P.L.L.C.

PATIENT MEDICAL HISTORY

ARE YOU IN GOOD HEALTH? _____

WHEN WAS YOUR LAST PHYSICAL EXAM? _____

IF YOU ARE UNDER THE CARE OF A PHYSICIAN, PLEASE GIVE REASON(S) FOR TREATMENT. _____

_____

PHYSICIAN'S NAME_____ADDRESS_____

CITY_____STATE_____ZIP_____PHONE (_____) _____

ARE YOU TAKING ANY MEDICATIONS AT THIS TIME? YES____ NO____

IF YES, WHAT ARE THEY? _____

_____

DIABETES LAST A1C_____DO YOU CHECK YOUR BLOOD SUGAR REGULARLY? YES_____NO____

HAVE YOU EVER BEEN ADMITTED TO THE HOSPITAL? YES____ NO____

IF YES, FOR WHAT (INCLUDE DATES IF KNOWN).____

_____

HAVE YOU EVER HAD AN UNUSUAL REACTION TO AN ANESTHETIC OR DRUG? YES____ NO____

IF YES, EXPLAIN _____

_____

HAVE YOU EVER HAD TROUBLE WITH PROLONGED BLEEDING AFTER SURGERY? YES____ NO____

ARE YOU ALLERGIC TO LATEX OR RUBBER PRODUCTS? YES____ NO____

ARE YOU ALLERGIC TO ANY MEDICATION OR OTHER SUBSTANCE? YES____ NO____

ARE YOU TAKING OR HAVE YOU PREVIOUSLY TAKEN MEDICATION FOR OSTEOPOROSIS SUCH AS FOSAMAX, ACTONEL OR ZOMETA? YES____ NO____

*******PLEASE CIRCLE Yes or No*******

YES NO HEART TROUBLE, HEART ATTACK, STROKE
YES NO PACEMAKER
YES NO HYPERTENSION, HIGH BLOOD PRESSURE
YES NO PAIN IN CHEST / SHORTNESS OF BREATH
YES NO SWELLING IN ANKLES
YES NO ARTIFICAIL HEART VALVE
YES NO ARTIFICIAL JOINTS (KNEE, HIP, ETC.)
YES NO SORES THAT DO NOT HEAL IN 1 WEEK
YES NO UNUSUAL WEIGHT GAIN OR LOSS
YES NO ASTHMA, HAY FEVER
YES NO RADIATION TREATMENT
YES NO THYROID CONDITION
YES NO CHRONIC SINUS PROBLEMS
YES NO TUBERCULOSIS
YES NO SEIZURES, FAINTING SPELLS, EPILEPSY
YES NO WOMEN – ARE YOU PREGNANT
YES NO HIV/AIDS

YES NO KIDNEY TROUBLE
YES NO LIVER TROUBLE
YES NO STOMACH OR DIGESTIVE DISORDERS
YES NO ULCERS
YES NO HEPATITIS
YES NO JAUNDICE
YES NO ARTHRITIS
YES NO BLOOD DISORDERS, ANEMIA
YES NO ABNORMAL BLEEDING
YES NO BLACK-OUTS
YES NO DIABETES
YES NO HYPOGLYCEMIA
YES NO EATING DISORDERS
YES NO DO YOU SMOKE
YES NO TUMORS, LESIONS, CANCER
YES NO WOMEN- DO YOU TAKE BIRTH CONTROL PILLS?

IS THERE ANY OTHER INFORMATION THAT SHOULD BE KNOWN ABOUT YOUR HEALTH OR ABOUT PREVIOUS DENTAL VISITS?_____

_____

_____