WINTER SPRINGS ENDODONTICS

NAME:	REFERRING DOCTOR:
ADDRESS:	EMERGENCY CONTACT:
CITY: STATE: ZIP:	PHONE:
HOME PHONE:	ADDRESS:
WORK PHONE:	**INSURANCE INFORMATION**
SOCIAL SECURITY NO.:	COMPANY:
BIRTH DATE:	ADDRESS:
OCCUPATION:	CITY: STATE: ZIP:
EMPLOYER:	PHONE: GROUP#:
BUSINESS ADDRESS:	RELATION TO EMPLOYEE: SELF ☐ SPOUSE ☐ CHILD ☐
CITY: STATE: ZIP:	
SPOUSE/PARENT	**RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS**
NAME:	I authorize the release of any dental information necessary in order to process insurance claims, and I authorize payments of dental benefits to Michael D. Louria, DMD and/or Robin B. Dodd, DDS for professional services rendered. I agree that I am responsible for all dental fees and that my insurance is filed as a courtesy to me. I am responsible for any outstanding insurance balance over 60 days of date of service.
EMPLOYER: PHONE:	
BUSINESS ADDRESS:	
CITY: STATE: ZIP:	
SOCIAL SECURITY NO.: D/O/B:	

HEALTH HISTORY

	YES	NO		YES	NO		YES	NO
AIDS or ARC			Dizziness/Fainting			Kidney Disease		
Allergies/Drugs/Latex			Drug/Alcohol Addiction			Liver Disease		
Artificial Joint/Valve			Frequent Swollen Ankles			Low Blood Pressure		
Asthma			Gastrointestinal/Ulcers			Lung Disease		
Bleeding Tendency			HIV Positive			Nervous Problems		
Bronchitis			Heart or Chest Pain			Pregnant/Nursing		
Cancer			Heart Murmur/MVP			Radiation Therapy		
Chemotherapy			Heart Trouble/Pacemaker			Recent Illness		
Convulsions/Seizures			Hepatitis			Rheumatic Fever		
Cortisone or Steroids			Herpes			Tuberculosis		
Diabetes/Hypoglycemia			High Blood Pressure			Thyroid Problems		
ARE YOU UNDER THE CARE OF A PHYSICIAN?						Dr.?		
HAVE YOU EVER BEEN HOSPITALIZED FOR A SERIOUS ILLNESS?								
HAVE YOU EVER RESPONDED UNFAVORABLY TO DENTAL CARE?								
IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT?								
HAVE YOU EVER TAKEN THE DIET PILLS PHEN-FEN OR REDUX?								
HAVE YOU EVER TAKEN MEDICATION FOR OSTEOPOROSIS OR HIGH BLOOD CALCIUM?								

HAVE YOU HAD AN UNFAVORABLE ALLERGIC DRUG REACTION TO: Circle Please

None	Codeine	Erythromycin	Cleocin
Penicillin	Keflex	Anesthetics	Other?

I AM PRESENTLY TAKING: Circle Please

No Drugs	Pain Medication	Birth Control	Blood Thinner/ Aspirin
Antibiotic	Herbal Medications	Cortisone/Steroids	Blood Pressure Medicine

Other:

PATIENT SIGNATURE: **DATE:**