DR. BATNIJI & ASSOCIATES

Practice Limited to Endodontics

The Following Confidential Information is for Our Records Only:

Name: LAST FIRST MI ☐Mr. ☐Mrs. ☐Miss ☐Dr.

☐Male ☐Female Birthdate: Age: Height: Weight:

SS #: DL # ☐Single ☐Married ❒ Email

Home Address: STREET CITY STATE ZIP

Home #: Cell /Mobile #: Work #: Ext:

Referring dentist: Phone #: **Physician:** Phone #:

Employer: How long there:

Employer's Address: Occupation:

Where & when are best times to reach you? Other family members seen by us:

SPOUSE INFORMATION: Name:

Employer:

WK #: Ext: SS #:

Birthdate: DL #:

In the event of an emergency, is there someone who lives near you that we should contact?

Name: Relation:

Wk #: HM #:

PRIMARY DENTAL INSURANCE:

Address:

Phone #:

Group #: Employer:

Insured's Name: Relation:

Insured's Birthday: / / *Insured's* SS #:

SECONDARY DENTAL INSURANCE:

Address:

Phone #:

Group #: Employer:

Insured's Name: Relation:

Insured's Birthday: / / *Insured's* SS #:

If answer is yes, please circle the condition.

	Check one Yes	No
1) Are you now in good health?	○	○
2) Are you taking any medication at present? If yes, what?	○	○
3) Are you now, or have you been under the care of a physician?	○	○
4) Are you sensitive or allergic to any drugs or materials? Penicillin/Sulfa Drugs/Aspirin/Codeine/Latex/Other?	○	○
5) Are you subject to profuse bleeding?	○	○
6) Does dental treatment make you nervous? Slightly / Moderately / Extremely	○	○
7) Have you ever used any diet drugs such as Pondimin, "Phen-Phen" or "Redux"?	○	○
8) Have you been treated with the intravenous bisphosphonates (Aredia, Zometa, Fosamax, Actonel) for bone pain, hypercalcemia or skeletal complications from Paget's disease, multiple myeloma or metastatic cancer?	○	○
9) Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	○	○
10) Have you had a history of heart murmur, mitral valve prolapse, artificial heart valves, rheumatic fever, heart trouble, high blood pressure or epilepsy?	○	○
11) Do you wear a cardiac pacemaker, or have you had any heart surgery?	○	○
12) Have you had a history of diabetes, kidney or liver disorders, pneumonia, hepatitis or jaundice?	○	○
13) Do you have active Tuberculosis, persistent cough greater than a 3 week duration, cough that produces blood, or been exposed to anyone with tuberculosis?	○	○
14) Have you ever had a local anesthetic (Novocaine, etc.)?	○	○
15 Have you ever had any unfavorable reaction from ❒ Local Anesthetic ❒ General Anesthesia?	○	○
16) Have you had any serious trouble associated with any previous dental treatment?	○	○
17) Do you need to be pre-medicated with antibiotics prior to your dental treatment?	○	○
18) Have you had any kind of sexually transmitted disease including HIV or AIDS?	○	○
19) Do you have any disease, condition, or problem not listed that you think we should know about? If so, what?	○	○
WOMEN ONLY Are you pregnant, nursing or taking birth control pills? If pregnant, number of weeks:	○	○

SIGNED **DATE**

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

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