SAN JOSE ENDODONTICS

Name: ____
Last (Mr. Mrs. Ms.) First Middle Initial

Birth Date ____________________ Social Security # ___________________________

Home Address _______________________________________Home Phone_____________________

____Other Phone _____________________
City State Zip

Referring Dentist ______________________Medical Physician/Phone___________________________

Emergency Contact __________________________________ Phone ____________________________

MEDICAL HISTORY

How would you rate your current health? (circle one) Good Fair Poor

Have you been hospitalized or had any recent prolonged illness or disease? ________________________

Are you now using any prescribed medications? If so, please list: ________________________________

____

Are you sensitive or allergic to any dental anesthetic? ____

Are you sensitive or allergic to any medications? ____

Have you taken bisphosphonates such as Fosamax in the past? __________________________________

(Women) Are you pregnant or nursing? ____

Do you have or have you had any of the following? **Please circle Yes or No**

Yes No **Alcoholism**	Yes No **Glaucoma**	Yes No **Liver disease**
Yes No **Allergies to latex**	Yes No **Heart attack**	Yes No **Problems healing**
Yes No **Allergies to metals**	Yes No **Heart disease**	Yes No **Psychiatric care**
Yes No **Angina**	Yes No **Heart murmur**	Yes No **Recreational drugs**
Yes No **Asthma**	Yes No **Heart valve replacement**	Yes No **Sinus trouble**
Yes No **Bleeding problems**	Yes No **Hepatitis: A, B or C**	Yes No **Stroke**
Yes No **Cancer**	Yes No **High Blood Pressure**	Yes No **Ulcers**
Yes No **Diabetes**	Yes No **H.I.V.**	Yes No **Venereal disease**
Yes No **Dizziness or Fainting**	Yes No **Joint replacement**	
Yes No **Epilepsy/Convulsions**	Yes No **Kidney disease**	Dr's. Initials: _____________

Other health condition(s) which we should be aware of? ____

____

Do you allow our office to e-mail your x-rays to other dental offices? YES NO _____ Patient Initials
I am aware that this office is HIPAA compliant. ______ Patient Initials

Signature ____ Date ______________________________
(Patient, Parent or Guardian)

I confirm as true the above medical history information and give consent to agreed upon dental services and use of appropriate methods on my behalf.

IF YOU DO NOT INTEND TO PAY CASH IN FULL TODAY, PLEASE CONTINUE ON REVERSE SIDE.

For doctors use only. Medical updates: Date/Init _________ Date/Init__________ Date/Init_________

PLEASE PROVIDE US WITH THE FOLLOWING DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

Employee Name ____________________

Birth Date _________________________

SS# or ID# ________________________

Employer __________________________

Dental Ins. Co. ______________________

SECONDARY INSURANCE

Employee Name ______________________________

Birth Date ___________________________________

SS# or ID# ___________________________________

Employer _____________________________________

Dental Ins. Co. ________________________________

I hereby authorize my insurance benefits to be paid directly to San Jose Endodontics. I am financially responsible for services not covered or paid for by my insurance company for any reason. I also authorize this office to release any information required about my dental condition/treatment needed to determine benefits for as long as it takes to have the claim settled.

Signature ____ Date ______________________
(Patient, Parent or Guardian)

SAN JOSE ENDODONTICS

David Y. Chow, D.D.S., M.S.
Gary W. Moss, D.D.S.

COVID-19 Patient Screening Form

Are you fully vaccinated for COVID-19?	1ST Dose Yes ☐ No ☐ Date:	2nd Dose Yes ☐ No ☐ Date:
Are you experiencing more than one of the following symptoms: shortness of breath, dry cough, sore throat, unexplained muscle pain, headache or nausea, new loss of taste or smell?	Yes ☐	No ☐
Even if you don't currently have any of the above symptoms, have you experienced more than one of these symptoms in the last 14 days?	Yes ☐	No ☐
Have you been advised to quarantine due to close contact with someone diagnosed with COVID-19?	Yes ☐	No ☐
Have you been tested for COVID-19 in the last 14 days? If "no," proceed to next question. If yes, what is the result of the testing?	Yes ☐ Positive ☐	No ☐ Negative ☐
Have you traveled out of state in the last 14 days?	Yes ☐ Location: ________ Date: ________	No ☐
Have you traveled out of country in the last 14 days?	Yes ☐ Location: ________ Date: ________	No ☐

____________________ ________________

Patient/Parent/Guardian Signature Date

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