HEALTH HISTORY

WESTSIDE ENDODONTICS
434 South First Avenue
Hillsboro . OR 97123
b . 503 . 693 . 6163
f . 503 . 693 . 6073

A. Steven Singh DDS

In order to serve you better, please fill out both sides of this form carefully and completely. If you have any questions, or need assistance, our staff will be happy to help you.

Name:__________ F/M_____ Age:_____ Today's Date:__________

Address:__________ City:__________ State:____ Zip:_____

Home Phone:__________ Work Phone:__________ Cell Phone: __________

Occupation:__________ Employer:__________

Work Address:__________

S.S. #:__________ D.O.B.:__________

Do you have Dental Insurance? Y/N

Insurance Co:__________ Group/Program #:__________

Address:__________ Phone #:__________

Name of Primary Subscriber:__________ S.S.#:__________

D.O.B.:__________

General Dentist:__________ Date of last visit:__________

Physician:__________ Date of last visit:__________

Reason for seeking treatment today:__________

Who referred you?__________

Please list any family members treated at this office:__________

This questionnaire is used by the doctor to ensure safe treatment. It is for your own health and safety that we ask that you please answer all questions as accurately as possible.

1. Are you in good health? Y/N

2. Pregnant? Y/N   3. Currently under physician's care? Y/N (please specify):__________

4. What allergies do you have?:__________

5. Have you had any unusual reactions to any medications or drugs?: Y/N (please specify):

6. Height:_____ Weight:_____ Physician:__________ Physician's Phone:__________

- ❑ Aids/HIV
- ❑ Allergy to Latex
- ❑ Anemia
- ❑ Angina/Chest Pain
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Bleeding Problems
- ❑ Bypass/Surgery
- ❑ Cancer
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy/Seizure
- ❑ Glaucoma
- ❑ Head or Neck Surgery
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Hepatitis/Jaundice
- ❑ High Blood Pressure
- ❑ Irregular Heartbeat
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Organ Transplant
- ❑ Pacemaker
- ❑ Prosthetic Heart Valves
- ❑ Psychiatric Treatment
- ❑ Radiation Treatment
- ❑ Renal Dialysis
- ❑ Rheumatic Fever
- ❑ Stomach Ulcers
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Transfusion History
- ❑ Tuberculosis (TB)
- ❑ __________
- ❑ __________
- ❑ __________

The above information is correct to the best of my knowledge. I authorize Westside Endodontics to release any or all records attained and collected at this office to my insurance carrier and my referring doctor.

Patient Signature: __________

Please turn over to other side.