Walnut Creek Endodontics
David F. Aimar D.D.S., Inc
Robert D. Bernie D.D.S., Inc
Daryl Dudum D.D.S.

Patient's Legal Name: _____ Age: _____

Name you prefer to be addressed_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (____) _____-_____ Work: (____) _____-_____ Cell: (____) _____-_____

Employer's Name: _____

SSN # _____-_____-_____ Date of Birth: _____/_____/_____

If married, Spouse's name: _____ Date of Birth: _____

Who is your referring Dentist? _____ Phone: _____-_____

Medical Physician: _____ Phone: _____-_____

If you are a *KAISER MEMBER*: KAISER #_____ Location: _____

Person Responsible For Account: _____

Is this visit due to an accident? YES / NO If so, when? _____

DO YOU CURRENTLY HAVE OR HAD ANY OF THE FOLLOWING? ***Circle YES or NO***

Y or N – Any Heart Problems	*Y or N – Sinus Problems*	*Y or N – AIDS/HIV*
Y or N – High Blood Pressure	Y or N – Heart Murmur	Y or N – Ulcers
Y or N – Low Blood Pressure	Y or N – Tuberculosis	Y or N – Stroke
Y or N – Malignancies	Y or N – Diabetes	Y or N – Asthma
Y or N – Excessive Bleeding	Y or N – Hepatitis A,B,C	Y or N – TMJ
Y or N – Circulatory Problems	Y or N – Arthritis	Y or N – Anemia
Y or N – Oral Herpes	Y or N – Radiation Treatment	Y or N – Rheumatic Fever

Y or N – Do you take aspirin daily? **Y or N – Latex Allergy**

Y or N – Has your Medical Physician recommended that you pre-medicate with Antibiotics prior to receiving dental treatment each time you visit the Dentist?

Are you allergic to any medications? Please list: _____

If female, do you take birth control pills? Y or N Are you pregnant? Y or N
Are you nursing? Y or N
Have you had heart surgery? Y or N If yes, when? _____
Do you have any prosthesis (plastic, metal bone/joint replacement) Y or N
If YES, please explain: _____
Are there any other medical or dental conditions that could affect treatment? Y or N
If YES, please explain: _____

What medications are you currently taking: _____

_____.

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED EVERY QUESTION COMPLETELY AND ACCURATELY.
I WILL INFORM MY DENTIST OF ANY CHANGE IN MY HEALTH OR MEDICATION PRIOR TO TREATMENT.

SIGNATURE OF PATIENT/PARENT: _____ DATE: _____

HEALTH HISTORY UPDATED: _____ DATE: _____