HARRY SINGH, DDS
& ASSOCIATES

PROGRESSIVE ENDODONTICS

Caring. Comfort. Results.

Patient Information

Date: ____________________

Referred by: ____

Patient Name: ____

Residence: Street: ____
City: ____________________ State: _____ Zip: ________________

Home Phone: ____________ Work: ____________ Cell: ________________

Patient Date of Birth: _________ Social Security#: __________________

Email Address: ___________________ **you**

May we use your email address to contact regarding your appointment? (Y) ___ (N) ___

Person to notify in case of emergency:
Name: _________________________ Telephone: _________________

Dental Insurance? Yes / No (circle one) Name of insurance ____________________
Policy or ID Number: __________________ Group: ______________________
Name of Insured: ______________________ Insured Date of Birth: ____________
Secondary Insurance Company: ____

Medical History (Circle one for each category)

Latex Allergy?	Yes	No	HIV positive?	Yes	No
Diabetes?	Yes	No	Ulcers?	Yes	No
Rheumatic fever?	Yes	No	Take blood thinners?	Yes	No
Liver Disease?	Yes	No	Are you a bleeder?	Yes	No
Hepatitis?	Yes	No	Stomach Problems?	Yes	No
Tuberculosis?	Yes	No	Hormone/birth control?	Yes	No
Thyroid Disease?	Yes	No	Are you pregnant?	Yes	No
Anemia?	Yes	No	Penicillin Allergy?	Yes	No
Kidney disease?	Yes	No	Other Allergies?	Yes	No
Heart disease?	Yes	No	List: ____________________________		
(specify: high blood pressure, angina, heart attack, etc.) ________________ ______________________________			**Hip or other joint replacement?**	Yes	No
			If yes, when: _______________________		

Do you **routinely take antibiotics** before dental appointments? Yes No
Do you have Primary care physician? Yes ____ Dr. ________________ No ____
Do you have any other medical condition or disease? ______________________________

Medications currently taken: ____

Signature: ________________________________ Date: ________________