Hudson Valley Endodontics

Dr. Peter Ham
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Practice Limited to Endodontics
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(**Please Circle**)
Mr., Mrs., Ms., Miss.,

Patient First Name_____ Middle Initial _____ Last Name _____
Home Phone Number _____ Date of Birth_____ SSN#_____
Address_____ City_____ State_____ Zip _____
Employer (Company Name) _____ Work/Cell Number_____
Referring Dentist_____ Dental Insurance_____
Physician_____ Physician phone _____
Emergency Contact_____ Phone Number_____
Pharmacy Used _____

Have you ever had any reaction to dental anesthetic/ Epinephrine? Yes_____ No_____
If yes, please explain:_____
Have you been hospitalized within the past 2 years? Yes_____ No _____
If yes, please explain: _____
Do you have any sensitivity to Latex? Yes_____ No _____
Have you ever experienced abnormal bleeding? Yes_____ No_____
FOR WOMEN ONLY: Could you be pregnant now? Yes_____ No_____

Please **CIRCLE** any of the following which you presently have or have had in the past:

Mitral Valve Prolapse	Liver Disease	Glaucoma
Heart Murmur	Hepatitis	Arthritis
Irregular Heart Beat	Neurological/Psychiatric	Malignancy (Cancer)
Rheumatic Fever	Nervousness (Panic Attacks)	Chemotherapy
Pacemaker	Aids or HIV	Sexually Transmitted Disease
Low Blood Pressure	Asthma	Joint / Hip Replacement
High Blood Pressure	Sinus	Hemophilia
Stroke	Tuberculosis	Chronic Cold Sores
Epilepsy	Ulcers	
Kidney Disease	Diabetes	Other Not Listed _____

Please List ALL Medications that you are currently taking _____

Have you ever had an allergic reaction to any medication YES_____ NO_____
If yes, which ones? _____
What type of reaction_____

WARNING! Failure to Disclose Any Past/Present Medical Condition May Adversely Affect Your Care.

SIGNATURE_____ DATE_____
(Parent or guardian if patient is minor)
DOCTOR'S SIGNATURE _____DATE_____