The Endodontic Center of Pleasanton Intake Form

This will be shredded immediately after entered into a secure electronic chart.

Last Name: _____First:_____MI:_____

Address:_____City_____Zip_____

Do you go by a Nickname? _____Email: _____

Best Phone Number to Contact You: *HOME OR CELL* _____

Social Security Number: _____ Sex: ***M or F*** Date of Birth _____

PREFERRED PHARMACY LOCATION AND NUMBER:_____

KAISER MEMBER # IF YOU HAVE ONE:_____

If patient is under 18, are you: PARENT or GUARDIAN ?
Name/Contact of Parent/Guardian:_____

Name & Phone Number of Emergency Contact: _____

Who is responsible for copayment?_____

Do you have Dental Insurance?_____If YES, please have all information ready for intake.

Who Referred you here?_____General Dentist: _____

Do you have a LATEX ALLERGY?_____Do you have a PENICILLIN ALLERGY?_____

Has a Physician recommended you take Pre-Med antibiotics before dental treatment and why? _____
_____

If YES, did you take your PRE-MED and what did you take?_____

Are you taking any medications for your Tooth that the Doctor will be evaluating/treating right now?
_____

FEMALES: ARE YOU PREGNANT AND HOW MANY MONTHS? _____

DO YOU HAVE A PACEMAKER?_____

DO YOU TAKE ANY MEDICATIONS ON A REGULAR BASIS?
-***NO OR YES*** (IF YES, PLEASE FILL OUT THE OTHER PAGE.)

DO YOU HAVE ANY OTHER ALLERGIES OR ADVERSE REACTIONS?
-***NO OR YES*** (IF YES, PLEASE FILL OUT THE OTHER PAGE.)

ARE YOU ON ANY CURRENT MEDICAL TREATMENT OR DO YOU HAVE ANY MEDICAL CONDITION WE NEED TO KNOW FOR DENTAL CARE?
-***NO OR YES*** (IF YES, PLEASE FILL OUT THE OTHER PAGE.)