Jacob Burry, D.D.S., M.S. Diplomate ABE   Diane Brighton, D.D.S., M.S.D.

Patient Information (please Print)

Name: Ms. Mrs. Mr. Dr. ____ Birthdate: ____________

Address: ____City: ________________ State: _______ Zip: ________

Phone: Home: _______________________ Cel:__________________ Employer: _________________Work ph:____________

Email____SSN#____

Your Dentist: _____________________________ Your Physician: ____

Emergency Contact: _______________________________Relation: _________________________Phone :_________________

Dental Insurance:

Primary Dental

Insurance__________________________________Group#:____________________ID#________________________

Subscriber Name:____Relation:_______________________Birthdate:_________

Address: ____ City: ________________ State: _______ Zip: _______

Employer: _______________________________________ Work ph: __________________SSN#:_________________________

Secondary Dental

Insurance:_______________________________Group#:______________________ID#________________________________

Subscriber Name:______________________________Relation:______________________ Birthdate:_____________________

Address:____City_________________State:________Zip:_____

Employer:____Work ph: ______________________SSN#:_____________________

(1) Continued on pg 2

Medical History (Please Circle)

Are you under a physician's care now or during the last 2 years? YES/NO

Please circle any conditions which you have had or currently have:

Heart Disease	Excessive Bleeding	Osteoporosis
Angina Pectoris	Cancer/Tumor	Hepatitis A or E
High Blood Pressure	Radiation	Hepatitis B or C
Heart Murmur	Emphysema	Liver Disease
Rheumatic Fever	Tuberculosis (TB)	Blood Transfusion
Congenital Heart Defect	Asthma	Drug Addiction
Scarlet Fever	Sinus Trouble	Hemophilia
Prosthetic Heart Valve	Allergies or Hives	Epilepsy or Seizures
Cardiac Pacemaker	Diabetes	Fainting or Dizziness
Heart Surgery	Thyroid Disease	Nervousness
Artificial Joint	Chemotherapy	Psychiatric Treatment
Anemia	Cortisone (steroid) medications	Bruise Easily
Stroke	Glaucoma	Heart Failure
Kidney/Renal disease	TMJ (pain in jaw joint)	Heart Attack
Ulcers	HIV	Sexually Transmitted Disease

Have you had any major health changes in the last 2 years? YES/NO
If yes, please describe: ______________
____
____

Do you require Antibiotics prior to dental procedures? YES/NO
If yes, for what condition e.g. artificial joint, heart valve, MVP, etc. ________
____
____

Are you allergic to any medications? YES/NO
If yes circle
latex, xylocaine, penicillin, aspirin, codeine, other_____________________
____

Do you have a disease, problem or condition not listed?____

Do you smoke? YES/NO If yes, how often? ____.

Have you ever been treated for infective endocarditis? YES/NO

Are you or currently taking or have you taken bisphosphonates or anti-resorptive medications for bone density or cancer treatment e.g. Fosamax, Actonel, Zometa, Aredia, Boniva, Denosumab? ____

What Medications are you Currently Taking?____

WOMEN: Are you currently pregnant? YES/NO Due date:_____________. Do you anticipate becoming pregnant? YES/NO
Are you currently taking birth control medication? YES/NO

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my health, or if my medications change, I will inform the dentist at my next appointment. I have received a copy of "Notice of Privacy Practices" and Financial Responsibility, and I assign insurance benefits to be paid directly to Skagit Endodontics.

PRINT NAME____

Signature of Patient, Parent, or Guardian: ____ Date: ______________