ANDY SURESH, D.M.D., M.S.D. **EAST COBB ENDODONTICS, P.C.**

Name____Male/ Female ☐ Single ☐ Married ☐Divorced ☐Widowed
Last First Middle
Address____Birth Date_________________SS#________________________
City_________________________________ State__________ Zip______________ e-mail ____________________________
Home Ph._______________________ Work Ph.__________________________ Cell Ph ____________________________

Referring Dentist____ **How long with this Dentist**____________

Method of payment for today's visit: Care Credit/ Credit Card/ Check/ Cash
Emergency Contact ____Phone #__________________________________
Physician_________________________________ Phone # ____
1. Are you under a physician's care now? ☐Yes ☐No Nature of treatment__________________________________
2. Have you ever been hospitalized and/or had surgery? ☐Yes ☐No Reason__________________________________

3. Have you EVER had any of the following? Please check each box.

	YES	NO		YES	NO		YES	NO		YES	NO
High Blood Pressure			Mitral Valve Prolapse			Tuberculosis			Thyroid Problems		
Heart Attack			Heart Valve Replacement			Hepatitis			Organ Transplant		
Stroke			Artificial Joint			Jaundice			Diabetes		
Arrhythmias			Asthma			Liver Disorders			Epilepsy/Seizures		
Pacemaker			Seasonal Allergies			Kidney Disease			Severe Anxiety		
Rheumatic Fever			Sinus Problems			Arthritis			Blood Transfusion		
Heart Murmur			Respiratory Problems			AIDS/HIV Positive			Cancer		
Angina/Chest Pain			Ulcers			Drug Dependency			Syncope/Fainting		

4. Other medical concerns: ____
____
____

5. Are you currently taking any of the following? Please check each box.

	YES	NO		YES	NO		YES	NO
Antibiotics or Antibiotic Premedication			Aspirin			Thyroid Medications		
Medicine for High Blood Pressure			Anticoagulants (Blood Thinners)			Steroids		
Digitalis/Other Heart Medications			Tranquilizers (Valium)			Birth Control Pills		
Nitroglycerine			Sedatives			Pain Medications		
Antihistamines			Insulin/Diabetic Medications			Other Medications		

6. If you answered YES to any of the above, list name of the medication and dosage below: ____________________________
____

7a. Are you sensitive or allergic to any of the following medications? Please check each box.

	YES	NO		YES	NO		YES	NO		YES	NO
Latex			Z-Pack			Epinephrine			Tylenol		
Penicillin/Amoxicillin			Erythromycin			Codeine			Ibuprofen		
Augmentin			Metronidazole/Flagyl			Hydrocodone			Aspirin		
Clindamycin			Topical Dental Anesthetics			Oxycodone			Steroids/Medrol Dose Pack		
Keflex			Lidocaine/ Novacaine			Tramadol			Other:_________________		

7b. What type of reaction did you have?____
8. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?………….. ☐ Yes ☐No
9. Do you have any disease, condition or problem not mentioned above?………………………………….… ☐Yes ☐No
10. Female Patients: Are you pregnant? ☐Yes ☐No If Yes, what month?_____________ Obstetrician________________________
11. Have you ever taken bisphosphonate medications? (ex: Fosamax, Actonel, Boniva)………………………. ☐Yes ☐No

To the best of my knowledge, all the above answers are true and correct. I will inform my dentist of changes in my health and/or medications.

Patient's signature__________________________ Date____________________ Reviewed________________
Patient's signature__________________________ Update__________________ Reviewed________________
Patient's signature__________________________ Update__________________ Reviewed________________