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 your visit (please circle one): ☐Credit Card ☐Care Credit ☐Check ☐Cash

MEDICAL HISTORY

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	☐	☐	Heart Valve Replacement	☐	☐	Liver Disorders	☐	☐	Epilepsy/Seizures	☐	☐
Heart Attack	☐	☐	Artificial Joint	☐	☐	Kidney Disease	☐	☐	Severe Anxiety	☐	☐
Stroke	☐	☐	Asthma	☐	☐	Cancer	☐	☐	Dental Anxiety	☐	☐
Arrhythmias	☐	☐	Sinus Problems		☐	AIDS/HIV Positive	☐	☐	Claustrophobia	☐	☐
Pacemaker	☐	☐	Respiratory Problems	☐	☐	Drug Dependency	☐	☐	Syncope/Fainting	☐	☐
Rheumatic Fever	☐	☐	Ulcers	☐	☐	Thyroid Problems	☐	☐	COVID-19	☐	☐
Heart Murmur	☐	☐	Tuberculosis	☐	☐	Organ Transplant	☐	☐			
Angina/Chest Pain	☐	☐	Hepatitis	☐	☐	Diabetes	☐	☐			
Mitral Valve Prolapse	☐	☐	Jaundice	☐	☐	Excessive Bleeding	☐	☐			

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	☐	☐
Prolia or Bisphosphonate (Fosamax, Boniva)	☐	☐	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. Female Patients: Are you pregnant? ☐Yes ☐No fIYes, what month?_____________ Obstetrician_________________________

9. Have you ever taken Prolia or 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________________