DR. RYAN J. GREENE
3811 Fairview Drive, Anderson IN 46013

GREENE ENDODONTICS

CONFIDENTIAL MEDICAL / PERSONAL HISTORY

Today's Date: ____________ Patient's Full Name: ____

Responsible party, if a Minor: ______________________________ Spouse's Full Name: ______________________________

Emergency Contact Name/Phone: ____

D.O.B: ____________ Age: _____ Sex: M / F Email: ______________________________ Spouse's D.O.B: ____________

Address: ______________________________ City: ____________________ State: ______ Zip: ____________

Home Phone: ____________________ Work Phone: ____________________ Cell Phone: ____________________

Patient SSN (Parent if Minor): ___________-_________-___________ Spouse SSN: ___________-_________-___________

Patient Employer (Parent if Minor): ______________________________ Spouse Employer: ______________________________

Referring Dentist: ______________________________ Full Time Student? Y / N If yes, where? ____________________

PRIMARY Dental Insurance Carrier: ______________________________ Policy #: ____________________

Insurance Holder Name & SSN: ______________________________ Employer that carries benefits: ____________________

SECONDARY Dental Insurance Carrier: ______________________________ Policy #: ____________________

Insurance Holder Name & SSN: ______________________________ Employer that carries benefits: ____________________

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If the tooth in question is a result of an accident, please give a brief description of the accident and date: ____________________

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Check any that apply:

◊ Angina	◊ Thyroid/Hormonal	◊ Tuberculosis	◊ Ulcers/Digestive
◊ Coronary	◊ Infectious Diseases	◊ Tumor/Cancer	◊ HIV Positive
◊ Surgery (heart)	◊ Latex Allergy	◊ Blood Thinner	◊ Anemia/ Bleeding
◊ Pacemaker	◊ Epilepsy/Fainting	◊ Artificial Joint	◊ Diabetes/Kidney
◊ Mitral Valve Prolapse	◊ Sinusitis	◊ Hypertension (high blood pressure)	◊ Hepatitis/liver
◊ Heart Attack	◊ Arthritis	◊ Immunosupression	◊ Herpes
◊ Heart Murmur	◊ Mental/Neural	◊ Prolonged Bleeding	◊ Asthma/Respiratory

If you checked any health item listed above, please explain: ____

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Recent hospitalizations, please explain & give date(s): ____

Are you allergic to any medications? Y / N If yes, explain: ____

List ALL medications you are taking: ____

Have you been told to take antibiotics before dental treatment, for your heart or artificial joint. Y / N Pharmacy & Phone Number: ________

Are you pregnant, nursing or using contraceptive birth control: Y / N If yes, explain: ______________________________

Your Physician's Name: ______________________________ Physician's Phone Number: ____________________

I have answered these questions to the best of my knowledge. I also understand that I will need to contact my regular dentist promptly, after completion of treatment, for the permanent (outside) restoration.

Signature: ______________________________ **Printed Name:** ____________________ **Date:** __________