PETER R. VANDERSLOOT, DDS
PRACTICE LIMITED TO ENDODONTICS

A Professional Corporation

Thank you selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us best meet all your dental healthcare needs, please complete this form in ink. If you have any questions or need assistance, please ask us, we will be happy to help.

Patient Information (Confidential)

Today's Date:_____

Name_____Phone#_____Social Security #_____
Address_____City & Zip_____Date of Birth_____
Patient's Employer_____Phone#_____Address_____
Referring Dental Office_____

Spouse/Parent Information

Spouse/Parent's Name_____ Soc. Sec. #_____ Date of Birth_____
Spouse/Parent's Employer_____Phone #_____
Person to Contact in Case of an Emergency_____Phone #_____
If Student, Name of School_____Full-Time ____ Part-Time ____

Patient Medical History

	Yes	No
Are you under any medical treatment at this time?	☐	☐
Are you currently taking any medications?	☐	☐
If yes, please list_____		
_____		
Within the past 5 years, have you been hospitalized?	☐	☐
For any surgical operation or serious illness?	☐	☐
_____		
_____		
Do you use tobacco?	☐	☐
Do you use controlled substances?	☐	☐
Have you ever taken bisphosphonates (Fosamax, Boniva, etc)?	☐	☐
Medication used for headache_____		

Are you allergic to any of the following?	Yes	No
Local Anesthetic……...	☐	☐
Penicillin or other antibiotics…….....	☐	☐
Sulfa Drugs……...	☐	☐
Barbiturates……...	☐	☐
Sedatives……....	☐	☐
Aspirin……...	☐	☐
Pain Medications……	☐	☐
Latex Rubber…….	☐	☐
Women Only:		
Are you or might you be pregnant?.....	☐	☐
Are you nursing?.....	☐	☐
Are you taking oral contraceptives?.....	☐	☐

Do you, or have you had any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Attack……..	☐	☐	TMJ/TMD……...	☐	☐	Fainting Seizures……..	☐	☐	Chest Pains	☐	☐
Heart Murmur……	☐	☐	Mitral Valve Prolapse.	☐	☐	Epilepsy/Convulsions…	☐	☐	Stroke……	☐	☐
Diabetes…….	☐	☐	Emphysema…….	☐	☐	Liver Disease…….	☐	☐	Cancer…...	☐	☐
AIDS/HIV…….	☐	☐	Radiation Therapy…...	☐	☐	Kidney Disease……..	☐	☐	Anemia…..	☐	☐
Heart Disease…….	☐	☐	Tuberculosis……	☐	☐	Stomach Trouble/Ulcers	☐	☐	Angina…...	☐	☐
Cardiac Pacemaker……	☐	☐	Hay Fever/Allergies…	☐	☐	Frequently Tired……	☐	☐	Asthma…..	☐	☐
Joint Replacement or Implant…	☐	☐	Rheumatic Fever…….	☐	☐	Thyroid Problem……	☐	☐	Glaucoma..	☐	☐
Hepatitis/Jaundice…….	☐	☐	Respiratory Problem...	☐	☐	Easily Winded……...	☐	☐	Leukemia..	☐	☐
Sexually Transmitted Disease...	☐	☐	Low Blood Pressure…	☐	☐	High Blood Pressure…..	☐	☐	Other_____		

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing false information can be dangerous to my health. I authorize the dentist to release information including diagnosis and records of treatment or examinations rendered to me or dependent to a third party payee &/or health practitioners. I authorize and request my insurance company to pay directly to Peter R. Vandersloot, DDS, PC. **I understand that the insurance information is an estimate only and not a guarantee of payment.** I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Method of Payment

Fees must be paid in full at the time of treatment. How will you be paying today?

_____Cash _____Check _____Visa _____MC _____Discover _____American Express

X_____

Signature of Patient (or parent if a minor)