Exeter Endodontics LLC

CRISTA E. MASSARO DMD

Demographics

Mr/ Ms/ Mrs/
Dr/ Fr/ Sr/ Hon

Circle one

First name_____ Last name_____
Nickname _____

Birthdate _____

Soc. Sec. _____ Gender ☐ Male ☐ Female ☐ Other

Guarantor_____

Employer_____

Contact Information

Street Address _____

Suite/Apt _____

City_____ State _____ Zip _____

Home Phone (____)_____ Alt. Phone (____)_____

Email _____

Provider and Referral

General Dentist _____

Dental Insurance Information

Dental Insurance carrier_____

Subscriber name _____ Date of Birth _____

ID number _____Group number _____

Pharmacy

Name_____ Location _____

3641 St. Lawrence Ave.
Reading, PA 19606
tele (484) 388-5600
fax (484) 388-5666
exeterendodontics1@gmail.com

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Name _____ Date _____

1. Are you in good health? ☐ Yes ☐ No ☐ Not sure ☐ N/A
   If not, please explain: _____

2. Have there been any changes to your general health in the past year?
   ☐ Yes ☐ No ☐ Not sure ☐ N/A
   If so, please explain: _____

3. Do you have any prosthetic joints or heart valves? ☐ Yes When? ____ ☐ No ☐ Not sure ☐ N/A

4. Do you take any kind of medications, pills or herbals? ☐ Yes ☐ No ☐ Not sure ☐ N/A
   If so, please list: _____

ARE YOU ALLERGIC TO OR HAD A REACTION TO ANY OF THE FOLLOWING:

5. Latex ☐ Yes ☐ No ☐ Not sure ☐ N/A

6. Local anesthetics ☐ Yes ☐ No ☐ Not sure ☐ N/A

7. Penicillin ☐ Yes ☐ No ☐ Not sure ☐ N/A

8. Other antibiotics ☐ Yes ☐ No ☐ Not sure ☐ N/A

9. Sulfites ☐ Yes ☐ No ☐ Not sure ☐ N/A

10. Aspirin ☐ Yes ☐ No ☐ Not sure ☐ N/A

11. Codeine, morphine or other opioid medications ☐ Yes ☐ No ☐ Not sure ☐ N/A

12. Any other medication allergies ☐ Yes ☐ No ☐ Not sure ☐ N/A
    Please list: _____

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS:

13. High blood pressure ☐ Yes ☐ No ☐ Not sure ☐ N/A

14. Low blood pressure ☐ Yes ☐ No ☐ Not sure ☐ N/A

15. Chest pain or angina ☐ Yes ☐ No ☐ Not sure ☐ N/A

16. Heart attack(s) ☐ Yes ☐ No ☐ Not sure ☐ N/A
    If yes, please explain: _____

(Please turn over page)

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17. Irregular heart beat ☐ Yes ☐ No ☐ Not sure ☐ N/A

18. Asthma ☐ Yes ☐ No ☐ Not sure ☐ N/A

19. Tuberculosis ☐ Yes ☐ No ☐ Not sure ☐ N/A

20. Jaundice, Hepatitis or Liver disease ☐ Yes ☐ No ☐ Not sure ☐ N/A

21. Fainting spells/chronic dizziness ☐ Yes ☐ No ☐ Not sure ☐ N/A

22. Convulsions/epilepsy ☐ Yes ☐ No ☐ Not sure ☐ N/A

23. Stroke ☐ Yes ☐ No ☐ Not sure ☐ N/A

24. Thyroid trouble hyper/hypothyroidism ☐ Yes ☐ No ☐ Not sure ☐ N/A

25. Diabetes ☐ Yes ☐ No ☐ Not sure ☐ N/A

26. Kidney trouble ☐ Yes ☐ No ☐ Not sure ☐ N/A

27. Are you on dialysis? ☐ Yes ☐ No ☐ Not sure ☐ N/A

28. Stomach ulcers ☐ Yes ☐ No ☐ Not sure ☐ N/A

29. Contagious disease ☐ Yes ☐ No ☐ Not sure ☐ N/A

30. Bleeding disorder ☐ Yes ☐ No ☐ Not sure ☐ N/A

31. HIV/AIDS ☐ Yes ☐ No ☐ Not sure ☐ N/A

32. Delays in healing ☐ Yes ☐ No ☐ Not sure ☐ N/A

33. Radiation treatment/chemotherapy ☐ Yes ☐ No ☐ Not sure ☐ N/A

DO YOU HAVE A HISTORY OF…

34. Drug abuse ☐ Yes ☐ No ☐ Not sure ☐ N/A

35. Alcohol abuse ☐ Yes ☐ No ☐ Not sure ☐ N/A

FOR WOMEN ONLY:

36. Is there any possibility that you are currently pregnant? ☐ Yes ☐ No ☐ Not sure ☐ N/A
If so, when is your due date? _____

37. Are you currently taking birth control pills? ☐ Yes ☐ No ☐ Not sure ☐ N/A

38. In case of emergency, who should we contact?
Name: _____ Relation to you: _____
Phone # _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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COVID-19 PANDEMIC PATIENT DISCLOSURES

This patient disclosure forms seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

In the past Ten Days…	Yes	No
Have you had or do you have a fever or above normal temperature?		
Have you experienced shortness of breath or had trouble breathing?		
Have you had or do you have a dry cough?		
Have you had or do you have a runny nose?		
Have you recently lost or had a reduction in your sense of smell?		
Have you had or do you have a sore throat?		
Have you been in close contact with someone who has tested positive for COVID-19 within the last **TEN** days?		
Have you tested positive for COVID-19?		
Have you been vaccinated against COVID-19?		
Have you traveled outside the United States by air or cruise ship in the past 30 days?		
Have you traveled within the United States by air, bus, or train within the past 14 days?		

I fully understand and acknowledge the above information, risk and cautions regarding a comprised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Patient's Signature _____ Date_____

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