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. NSAIDS/Aleve/Ibuprofen ☐ 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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Release Form for Dental X Rays

I, _____ D.O.B:_____ do hereby
(Print name) (Date of Birth)

give permission for Exeter Endodontics, LLC to obtain copies of my dental x-rays and/or treatment records from the providing dentist of my choice. I authorize the release of this requested information via HIPAA secure email or fax transmission protected by our office. This information will be strictly used to aid in the diagnosis and treatment of my specific dental problem for which I have been referred.

I direct Exeter Endodontics, LLC to act on my behalf to request the necessary treatment information and consent to the release of my dental records.

_____ Date:_____
(Signature of patient *or* parent/guardian)

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