



Flatirons Endodontics, LLC

Louisville
850 W South Boulder Rd Ste 201
Louisville, CO 80027
303-665-6120
Westminster
905 W 124th Ave Ste 160
Westminster, CO 80234
303-214-4100

Welcome to our Office

PATIENT INFORMATION

Name _____ Date _____

Address _____

City/State/Zip _____

Phone (h) _____ (w) _____ (c) _____

Date of Birth _____ General Dentist _____

Employer _____ SSN# _____

PAYMENT INFORMATION - You are responsible for payment when services are rendered. If for any reason your account goes to collections, you will be responsible for collection fees or any reasonable attorney fees.

DENTAL INSURANCE INFORMATION

Name of Insured _____ SSN/ID# _____

Insured's Date of Birth _____ Relationship to Patient _____

Employer _____ Insurance Company Name _____

Group # _____ Local # _____

Insurance Company Address/Phone# _____

MEDICAL HISTORY

Physician's Name _____ Phone _____

Are you allergic to or have you had side affects from any of the following?

Penicillin	Yes	No	Aspirin	Yes	No	Local Anesthesia	Yes	No
Other antibiotics	Yes	No	Codeine	Yes	No	Other medications	Yes	No

If yes to other, please list _____

Other environmental allergies _____

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

Heart problems	Yes	No	Sinusitis	Yes	No	Bleeding disorders	Yes
No							
High blood pressure	Yes	No	Thyroid treatment	Yes	No	Immune disorders	Yes
Low blood pressure	Yes	No	Asthma	Yes	No	Anemia	Yes
Heart murmur	Yes	No	Tuberculosis	Yes	No	Blood disease	Yes
Rheumatic fever	Yes	No	Diabetes	Yes	No	Blood transfusion	Yes
Mitral valve prolapse	Yes	No	Kidney disease	Yes	No	Hepatitis	Yes
Arrhythmia	Yes	No	Colitis	Yes	No	Chemotherapy	Yes
Stroke	Yes	No	Arthritis	Yes	No	Radiation therapy	Yes
Seizure	Yes	No	Joint replacement	Yes	No	Allergy to Latex	Yes

Other conditions not listed _____

Current medications _____

Recent hospitalizations _____

Have you ever been told to take antibiotic premedication prior to dental appointments? Yes No

Women: Are you pregnant? Yes No Nursing? Yes No Do you use birth control pills? Yes No

Emergency Contact Name _____ Phone _____

Signature _____ Date _____