Dr. Burton M. Waxman

5058 Dorsey Hall Drive, Suite 102
Ellicott City, Maryland 21042

Specialist in Endodontics

Patient's Name _____ Birth Date ____/____/____

Street Address _____

City _____ State _____ Zip_____

Social Security_____ Driver Lic #_____

Employer Name and Address _____

_____

Home Phone _____ Work Phone _____ Cell Phone _____

Dental Insurance _____ Group Number _____ I D Number _____

Insurance Co. Address _____

Insured Party's Name _____ Birth Date ____/____/____ Social Security_____

Employer Name and Address _____

_____

Home Phone _____ Work Phone _____ Cell Phone _____

General Dentist Name, Address and Phone _____

_____

MEDICAL HISTORY

Name of Physician _____

Physician's Address _____ Physician Phone _____

_____ Last Physical Exam _____

Have you been hospitalized in the last 5 years? Yes _____ No _____

If yes, for What? _____

Please list medications you are taking below:

Medication Name _____ Why _____

Medication Name _____ Why _____

Medication Name _____ Why _____

Medication Name _____ Why _____

Do you have, or have you had, any of the following - Please circle "Y" for Yes or "N" for No:

Y or N	Venereal Disease	Y or N	Radiation or Chemotherapy Treatment	Y or N	Diabetes
Y or N	Heart Disease (Angina, Heart Attack, Bypass)	Y or N	Thyroid or Parathyroid Condition	Y or N	Excessive Thirst/Urination
Y or N	Heart Murmur	Y or N	Alcohol or Drug Dependency	Y or N	Epilepsy or Neurological Prob
Y or N	Mitral Valve Prolapse	Y or N	Blood Transfusion	Y or N	Stroke
Y or N	Pacemaker or Artificial Valve	Y or N	Kidney Disorder	Y or N	Fainting or Dizziness
Y or N	Rheumatic Fever	Y or N	Pre-Medication	Y or N	Sinus Trouble
Y or N	High Blood Pressure	Y or N	Allergies (List Below)	Y or N	Glaucoma
Y or N	Shortness of Breath	Y or N	Hepatitis A____ B____C	Y or N	Ulcer or Colitis
Y or N	Unusual Swelling of Feet/Ankles	Y or N	Tuberculosis	Y or N	Organ Transplant
Y or N	Blood Disorder	Y or N	Liver Disease	Y or N	(WOMEN) Are you pregnant?
Y or N	Excessive Bleeding from cut or extraction	Y or N	Acquired Immune Deficiency (AIDS)	Y or N	Joint Replacement
Y or N	Malignancies/Cancer	Y or N	HIV Positive	Y or N	**Latex Allergy**

Allergies to Medication (i.e. Penicillin or "Novocaine") _____

◄ OVER ►

DENTAL HISTORY

Do you feel discomfort when your tooth comes in contact with:

Hot foods or liquids (soup, coffee, etc.?)	_____ Yes	_____ No
Cold foods or liquids (ice cream, cold water, etc.?)	_____ Yes	_____ No
Sweet or sour foods (candy, oranges, fruit, etc.?)	_____ Yes	_____ No
When you bite down or chew?	_____ Yes	_____ No
Do any of the above symptoms linger for more than a minute or so?	_____ Yes	_____ No

Comments: _____

_____

_____

_____

_____

I authorize treatment and agree to pay all fees charged for such treatment. I agree to pay all charges for myself and all members of my family promptly upon presentment thereof. I hereby authorize the release of any pertinent information to my insurance company. I acknowledge that payments will not be delayed or withheld because of any insurance coverage or because of the pendency of claims thereon. I acknowledge that all proceeds of insurance are assigned to this office where applicable and that this office assumes no responsibility for the collection of any proceeds of insurance.

I hereby authorize the release of any pertinent information to my insurance company and any other doctors involved with my care. If my account becomes assigned to a collection agency, I agree to pay 25 - 33 1/3% collection agency fees, court costs, and attorney fees. I understand that accounts with a balance over 60 days will be assessed a 1.5% late charge per month on the unpaid monthly balance.

Patient's Signature (guardian if minor) _____ 'SEAL'

Date _____/_____/_____