



**LANGLEY**  
ENDODONTICS

**Dr. Howard Bittner Inc.**  
**Dr. Jason Conn**  
Certified Specialists in Endodontics  
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**PLEASE PRINT**

Name \_\_\_\_\_ Home Tel # \_\_\_\_\_  
last first initial

Address \_\_\_\_\_ Work Tel # \_\_\_\_\_  
house # street city postal code

Email Address \_\_\_\_\_

Birthdate \_\_\_\_\_ Circle: Male / Female Spouse's Name \_\_\_\_\_  
day month year

Family Dentist \_\_\_\_\_ City \_\_\_\_\_

Family Physician \_\_\_\_\_ City \_\_\_\_\_

Parent/Guardian Name (if under 18 years): \_\_\_\_\_

Relative or Friends Name & Telephone (emergency) \_\_\_\_\_

**Dental Insurance**

Name of Policy Holder \_\_\_\_\_ Birthdate \_\_\_\_\_  
Day Month Year

Employer \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group Policy/Plan # \_\_\_\_\_ Cert # \_\_\_\_\_ Dep# \_\_\_\_\_

Relationship to Policy Holder \_\_\_\_\_

**Second Insurance Plan (if applicable)**

Name of Policy Holder \_\_\_\_\_ Birthdate \_\_\_\_\_  
Day Month Year

Employer \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group Policy/Plan # \_\_\_\_\_ Cert # \_\_\_\_\_ Dep # \_\_\_\_\_

Relationship to Policy Holder \_\_\_\_\_

**OVER**

# Confidential Medical History

Date of your last physical exam \_\_\_\_\_

Do you have a major medical problem? .....  YES  NO  
If yes, please describe: \_\_\_\_\_

Have you been hospitalized in the past 5 years? .....  YES  NO  
If yes, please describe: \_\_\_\_\_

Have you been in the care of a medical doctor during the past two years? .....  YES  NO  
If yes, for what reason? \_\_\_\_\_

Have you ever had excessive bleeding following medical/dental surgery? .....  YES  NO

Do you regularly take medication or drugs of any kind? .....  YES  NO  
If yes, please identify: \_\_\_\_\_  
\_\_\_\_\_  
It's purpose: \_\_\_\_\_

When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath or because you are very tired? .....  YES  NO

Has your medical doctor ever said you have a cancer or tumor? .....  YES  NO

WOMEN: Are you pregnant now? .....  YES  NO

Do you have heart trouble? .....  YES  NO

### Only Check Boxes that apply.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Heart Failure   | <input type="checkbox"/> Heart Valve Problems | <input type="checkbox"/> Congenital Heart Lesions              |
| <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> High Blood Pressure                   |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Heart Pacemaker      | <input type="checkbox"/> Low Blood Pressure                    |
| <input type="checkbox"/> Heart Attack    | <input type="checkbox"/> Heart Surgery        | <input type="checkbox"/> Mitral Valve Prolapse - Regurgitation |

### Check any of the following which you have had or have at present:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Ulcer              | <input type="checkbox"/> Tuberculosis                   |
| <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Glaucoma           | <input type="checkbox"/> Radiation Treatment            |
| <input type="checkbox"/> Diabetes Type 1 / Type 2 | <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Chemotherapy (Cancer/Leukemia) |
| <input type="checkbox"/> Epilepsy or Seizures     | <input type="checkbox"/> Sinusitis          | <input type="checkbox"/> Colitis                        |
| <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Fainting or Dizzy Spells       |
| <input type="checkbox"/> Artificial Joint         | <input type="checkbox"/> Emphysema          | <input type="checkbox"/> Psychiatric Treatment          |

### Diseases

- Kidney
- Liver

### Allergies (Drugs):

- Penicillin
- Local Anesthetic
- Codeine
- Aspirin
- Other \_\_\_\_\_

### Infectious Disease:

- HIV/Exposure to Aids
- Hepatitis B
- Hepatitis C

Any serious illness not listed? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**To the best of my knowledge, all of the preceding answers are true and correct. IF I EVER HAVE ANY CHANGE IN MY HEALTH, OR IF MY MEDICINES CHANGE, I WILL INFORM THE DOCTOR AT THE NEXT APPOINTMENT WITHOUT FAIL.**

Signature of Patient, Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_

Doctor's/Staff signature \_\_\_\_\_

Date \_\_\_\_\_