



# 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**

**Brian C Frutchev, DMD**

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

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 \_\_\_\_\_