Appt			

NAME _____ SOC. SEC.# _____

ADDRESS _____ DATE OF BIRTH _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ E-MAIL _____ SEX: ❑ MALE ❑ FEMALE

❑ SINGLE ❑ MARRIED SPOUSE OR PARENT'S NAME _____ WK PHONE _____

EMPLOYER _____ OCCUPATION _____

YOUR DENTAL INSURANCE _____ GROUP# _____

OTHER DENTAL INSURANCE _____ GROUP# _____

NAME OF SUBSCRIBER _____ BIRTHDATE _____

EMPLOYER _____ SOC. SEC. # _____

GENERAL DENTIST _____

PERSON TO CALL IN CASE OF EMERGENCY (other than spouse) _____ PHONE # _____

NAME & ADDRESS OF PHYSICIAN _____ PHONE # (if known) _____

DIAGNOSTIC TESTS:						PULP VITALITY				PERIO PROBING						X-RAY FINDINGS	INSTRUMENT RECORD					
DATE	NO	PERC	PALP	MOB	T. SLTH	HOT H20	HOT	ICE	COLD H20	MB	B	DB	DL	L	ML		DATE	NO	CANAL	REF	WL	SIZE

DATE	NO	

1. Are you in good health? ..... Yes___ No___
2. Are you presently under the care of a physician ..... Yes___ No___
   If yes, for what condition?
3. In the last five years have you been: (If yes, please explain)
   a. hospitalized? ..... Yes___ No___
   b. had a serious illness? ..... Yes___ No___
   c. had a major operation? ..... Yes___ No___
4. Have you had, or do you presently have, any of the following conditions? Please check yes or no)

Heart surgery, disease or attack	Yes___ No___	AIDS or HIV Positive: Date Tested_____	Yes___ No___
Angina Pectoris	Yes___ No___	Hepatitis, Jaundice or Liver Damage	Yes___ No___
High/low blood pressure	Yes___ No___	Blood transfusion	Yes___ No___
Heart murmur	Yes___ No___	Drug addiction/Alcoholism	Yes___ No___
Rheumatic Fever (RHD)	Yes___ No___	Hemophilia or excessive bleeding	Yes___ No___
Congenital Heart Lesions (MVP)	Yes___ No___	Sexually Transmitted Disease	Yes___ No___
Artificial heart valve	Yes___ No___	Cold sores	Yes___ No___
Heart pacemaker	Yes___ No___	Herpes	Yes___ No___
Artificial joint/prosthesis	Yes___ No___	Psychiatric treatment/mental disorders	Yes___ No___
Stroke	Yes___ No___	Allergies	Yes___ No___
Kidney disease	Yes___ No___	Asthma/Hay fever	Yes___ No___
Cancer or tumors	Yes___ No___	Sinus trouble	Yes___ No___
Chemotherapy/X-ray treatment	Yes___ No___	Seizures/Epilepsy	Yes___ No___
Lung disease/Tuberculosis	Yes___ No___	Thyroid disease	Yes___ No___
Diabetes	Yes___ No___	Arthritis	Yes___ No___

5. Please circle any of the following you are now taking:
   a. Antibiotics (which?)_____
   b. Anticoagulants
   c. High blood pressure medication
   d. Cortisone (steroids)
   e. Digitalis or heart medication; i.e. nitroglycerin
   f. Insulin or similar drug
   g. Pain medication (which?) _____
   h. Bisphosphonates
   i. Aredia (Pamidronate)
   j. Zometa (Zolendronic Acid)
   k. Fosamax (Alendronate)
   l. Actonel (Risedronate)
   m. Large doses of aspirin
   n. Other_____
6. Have you ever had an allergic or unusual reaction to any of the following medications? (Please check yes or no)

Dental local anesthetics	Yes___ No___	Penicillin	Yes___ No___
Aspirin, acetaminophen or ibuprofen	Yes___ No___	Erythromycin or other antibiotics?	Yes___ No___
Barbiturates or tranquilizers	Yes___ No___	Sulfa Drugs	Yes___ No___
Codeine or other narcotics	Yes___ No___	Any other medications or drugs?	Yes___ No___
		(Which?) _____	

7. WOMEN: Are you pregnant? Yes___ No___ If yes, how many months?_____
   Are you breast feeding: ..... Yes___ No___
   Are you taking birth control pills? ..... Yes___ No___
   (If you are taking birth control pills, please read the following: Antibiotics may inactivate birth control medication. Therefore if you need to take antibiotics during endodontic treatment additional birth control measures should be taken until your next menses.
8. Is there anything the dentist should know regarding you medical history that has not been mentioned? ..... Yes___ No___
   Please explain)_____
9. Have you ever had any serious complications involving dental treatment? ..... Yes___ No___
   Please explain)_____

I, the undersigned, being the patient, parent or guardian of the above minor patient, consent to the performing of whatever procedure may be determined necessary by the Doctor, including the administration of drugs and/or anesthetics. I also understand that upon completion of root canal therapy in this office I will be referred to my dentist for permanent restoration, such as an onlay or crown if needed.

Signed: _____ Dated: _____
(Parent or Guardian if minor)

Initial_____ Date_____ Initial_____ Date_____ Initial_____ Date_____ Initial_____ Date_____ Initial_____ Date_____

ENDODONTIC CONSENT AND INFORMATION FORM

We want our patients to be informed about the various procedures and risks involved in endodontic (root canal) therapy and to have their consent before starting treatment. Endodontic therapy is performed in order to save a tooth which otherwise might need to be removed. Determination of the need for endodontic therapy is made after a review of your signs, symptoms, and x-rays as well as information provided by your general dentist. The following discusses the possible risks that may occur during or following treatment.

MEDICATION RISK

Prescribed medications may cause drowsiness, lack of awareness and/or coordination. These effects may be compounded by the use of alcohol or additional medications. It is not advisable to operate any vehicle or machinery until you have recovered from the effects of medication. In addition, antibiotics have been reported to reduce the effectiveness of birth control pills in women. Additional methods of contraception are advised during the menstrual cycle in which the antibiotic is used.

RISKS SPECIFIC TO NONSURGICAL ENDODONTIC TREATMENT:

Included but are not limited to discomfort, infection and swelling. Damage to bridges, crowns or existing fillings and/or loss of tooth structure in gaining access to the canals, the possibility of small instruments breaking within the root canal and/or perforations (extra openings) in the crown or root of the tooth. During treatment complications may be discovered which require endodontic surgery or extraction. You will be advised of complications such as blocked canals due to prior fillings or prior treatment, natural calcification, broken instruments, curved roots, gum disease, and split or fractured teeth. These risks are in addition to the usual risks of general dental treatment and local anesthetic administration.

RISKS SPECIFIC TO SURGICAL ENDODONTIC TREATMENT

Included but are not limited to bleeding, discomfort, infection, swelling, sinus involvement, injury to other roots, and injury to nerves underlying the teeth resulting in numbness or tingling of the teeth, gums, lip, and/or tongue.

OTHER TREATMENT CHOICES

No treatment; waiting for more definitive signs or symptoms; tooth extraction. Risks of these choices include pain, infection, swelling and/or loss of teeth. If root canal treatment is started and not completed these same risks apply.

CONSENT

I, the undersigned, being the patient (or parent or guardian of minor patient) consent to the procedures decided upon to be necessary or advisable in the opinion of the doctor.
I also understand that upon completion of root canal therapy I shall return to my general dentist for permanent restoration of the tooth, as soon as possible. I understand that the root canal treatment is an attempt to save a tooth which would otherwise be extracted. Although this treatment has a high degree of success it cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery or even extraction. I have read and understand the above.

Patient/Parent/Guardian Signature Date