



THE FOLLOWING CONFIDENTIAL INFORMATION IS FOR OUR RECORDS ONLY

Name..... Spouse's Name.....
Date of Birth..... Spouse's Date of Birth.....
Social Security No..... Social Security No.....
If a Minor, Parent's Name..... Marital Status.....
Address..... Phone (.....).....
City..... State..... Zip..... Cell Phone.....
Employer/Spouse Employer.....
Address..... Phone (.....)..... Ext:.....
City..... State..... Zip.....
Physician..... Phone (.....).....
Referring Dentist..... Phone (.....).....
Dental Insurance Co..... Phone (.....).....
Who is responsible for this account.....
Who may we contact in case of an emergency? Name.....
Address..... Phone (.....).....

MEDICAL HISTORY

1. Are you in good health?..... YES NO
2. a. Have you been in a hospital or had a serious illness or accident within the past 2 years?..... YES NO
b. If so, what was the problem?..... YES NO
3. Are you under the care of a physician?..... YES NO
4. Are you allergic to: a. Local Anesthetics?..... YES NO
b. Penicilin or other antibiotics?..... YES NO
c. Codeine or other narcotics?..... YES NO
d. Other..... YES NO
5. Do you usually pre-medicate yourself for any dental treatments?..... YES NO

PLEASE COMPLETE THE FOLLOWING IN FULL (check one)

Table with 8 columns: Medical Condition, YES/NO, Medical Condition, YES/NO, Medical Condition, YES/NO, Medical Condition, YES/NO. Rows include Angina (Chest pain), Heart Trouble, Heart Murmur, Pace Maker, Damaged or Artificial Heart Valves, Heart Attack, Abnormal Blood Pressure, Rheumatic Fever, Anemia, Kidney Trouble, Asthma, Diabetes, Jaundice, Hepatitis, Tuberculosis, Sinus Trouble, TMJ, Aids, HIV, Immune Suppressive Disorders, Cancer, Epilepsy, Stomach Ulcers, Psychiatric Problems, Arthritis.

If you are presently using medication, please list.....

I understand that only the root canal therapy is to be done at this office. The permanent (outside) restoration (filling, inlay, crown, etc.) will be done by my regular dentist. Proper post-treatments restoration is a necessity.

Signature..... Date.....
Patient or Patient of Minor

WOMEN

6. Are you pregnant?..... YES NO
7. Are you nursing?..... YES NO