



Date _____ Social Security # _____

Name _____

Date of Birth _____ Nickname _____

Address _____

Home Phone _____ Cell _____

Work Phone _____

If Dental Insurance is not in your name, list **name & birth date** of person responsible:

EMERGENCY CONTACT INFO

Name _____ Phone _____

Relationship _____

Are you currently under the care of a physician? _____

If yes, explain: _____

List any drugs prescribed by a **physician or dentist**:

Are you pregnant or nursing? If yes, week # _____

Do you need to be pre-medicated before dental treatment? _____ Explain: _____

Have you ever had any of the following medical conditions? (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> HTV/Aids |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Drug/Alcohol Abuse |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric problems |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Cancer/Chemotherapy |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Fever Blisters |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Abnormal Bleeding/
Hemophilia |
| <input type="checkbox"/> Chronic Hepatitis | |
| <input type="checkbox"/> Diabetes | |

Have you ever experienced any medical conditions not listed previously? _____ If yes, please explain:

Are you allergic to any of the following?
 Penicillin Aspirin
 Household Bleach Latex
 Dental Anesthetics Codeine

Please list any other allergies:

Please rate your anxiety level regarding today's appointment: (circle one)

NOT Anxious **VERY Anxious**
 1 2 3 4 5

AGREEMENT

* I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical history.

* I consent to the necessary diagnostic procedures (including x-rays) to determine if root canal therapy is indicated, I will decide whether or not I wish to have treatment.

* I understand root canal treatment is a procedure to retain a tooth which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed.

Occasionally a tooth which has had root canal therapy may require retreatment, surgery, or even extraction.

* I understand that only the root canal treatment is to be performed at this office. The permanent (outside) restoration (filling, onlay, crown, etc) will be done by my regular general dentist.

* I acknowledge full responsibility for the payment for such services and agree to pay for them in full, unless other specific arrangements are made with the office manager. I understand that my dental insurance carrier may pay less than the actual bill for services, and I am responsible for the entire fee, regardless of my insurance company's arbitrary determination of "usual and customary rates."

* I authorize my insurance carrier to issue the dental benefits of my plan directly to this dental office. I also authorize release of information necessary to process dental insurance.

Signature _____ Date _____

* I acknowledge receipt of the included Notice of Privacy Practices for this office.

Signature _____ Date _____