

PATIENT INFORMATION CONFIDENTIAL

(PLEASE PRINT CLEARLY)

NAME \_\_\_\_\_ AGE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_  
          LAST           MR/MRS/MISS/MS           FIRST

CIRCLE

1. Are you having pain or discomfort at this time? \_\_\_\_\_ YES NO
2. Are you under the care of a medical doctor at the present time? \_\_\_\_\_ YES NO  
If yes, for what purpose? \_\_\_\_\_
3. Are you taking any medications at the present time? \_\_\_\_\_ YES NO  
If yes, please list \_\_\_\_\_
4. Are you allergic to (i.e.: itching, rash, swelling of hands, feet or eyes) or made sick by any drugs or medications? Please list \_\_\_\_\_ YES NO
5. **FOR WOMEN ONLY:** Are you pregnant now? \_\_\_\_\_ YES NO  
Are you taking birth control pills? \_\_\_\_\_ YES NO  
Are you nursing? \_\_\_\_\_ YES NO

6. Circle any of the following which you have had or have at present:

- |                          |                        |                            |
|--------------------------|------------------------|----------------------------|
| Heart Failure            | Artificial Joint       | Chemotherapy               |
| Heart Disease/Attack     | Anemia                 | (Cancer Radiation Therapy) |
| Angina Pectoris          | Stroke                 | Arthritis                  |
| High Blood Pressure      | Kidney Trouble         | Glaucoma                   |
| Heart Murmur             | Ulcers                 | Pain in Jaw Joints         |
| Mitral Valve Prolapse    | Emphysema              | AIDS                       |
| Rheumatic Fever          | Chronic Cough          | HIV Positive               |
| Congenital Heart Lesions | Tuberculosis (TB)      | Hepatitis A (infectious)   |
| Scarlet Fever            | Asthma                 | Hepatitis B (serum)        |
| Artificial Heart Valve   | Sinus Trouble          | Liver Disease              |
| Heart Pacemaker          | Allergies              | Blood Transfusion          |
| Heart Surgery            | Thyroid Disease        | Drug Addiction             |
| Hemophilia               | Venereal Disease       | Genital Herpes             |
| Nervousness              | (Syphillis, Gonorrhea) | Epilepsy or Seizures       |
| Psychiatric Treatment    | Sickle Cell Disease    | Bruise Easily              |
|                          |                        | Diabetes                   |

7. Do you have any diseases, conditions or problems not listed? \_\_\_\_\_ YES NO  
If yes, please list \_\_\_\_\_

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I understand that it is my responsibility to advise your office of any changes in my medical history.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

MEDICAL HISTORY/PHYSICAL EVALUATION UPDATE

DATE	ADDITION	INITIAL
_____	_____	_____

Root canal treatment is an attempt to retain a tooth that may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth that has had root canal therapy may require retreatment, surgery, or even extraction.

I also understand that the root canal filling restores only the root portion of the tooth. The crown portion must be restored by an additional procedure, for an additional expense by your dentist. Teeth having pre-existing crowns and/or bridges may require new crowns and/or bridges after completion of root canal therapy.

Date \_\_\_\_\_ Signature \_\_\_\_\_