PATIENT INFORMATION

Name _____ Referred By _____

Address _____ Employer _____

City & Zip _____ Employer Phone # _____

Phone # _____ Occupation _____

Cell Phone # _____ Spouse/Parent _____

Age _____ Birthdate _____ Spouse Employer _____

Sex _____ Marital Status _____ Spouse Birthdate _____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

Insured's Name _____

Insured's Soc. Sec. # _____

Insurance Co. _____

Insurance Co. Address _____

Phone # _____ Group # _____

SECONDARY INSURANCE

Insured's Name _____

Insured's Soc. Sec. # _____

Insurance Co. _____

Insurance Co. Address _____

Phone # _____ Group # _____

MEDICAL HISTORY

	YES	NO
1. Are you presently under a physician's care? Family Physician _____	☐	☐
If so, please specify _____		
2. Are you presently taking any medications (prescription or over-the-counter)?	☐	☐
If so, please specify _____		
3. Are you currently taking or have you previously taken bisphosphonate medicatons, such as Actonel®, Fosamax® or Zometa, within the past twelve years?	☐	☐

4. Do you, or have you had any of the following? Please check.

- ☐ High blood pressure
- ☐ Heart murmur or prolapsed valve (MVP)
- ☐ Joint prosthesis (hip, knee, etc.)
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Congenital heart disease
- ☐ Cardiovascular disease: heart attack, stroke, by-pass
- ☐ Prosthetic heart valve
- ☐ Blood disorder (e.g. anemia)
- ☐ Asthma
- ☐ Temporomandibular joint problems (TMJ)
- ☐ Sinus trouble
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Stomach ulcers, colitis
- ☐ Hepatitis, jaundice, liver disease
- ☐ Alcoholism
- ☐ Immune System Disorder (e.g. HIV)
- ☐ Kidney problems
- ☐ Psychiatric treatment
- ☐ Fainting spells or seizures
- ☐ Epilepsy
- ☐ Cancer
- ☐ Arthritis
- ☐ Other _____

5. If any of the above conditions are checked, is it or are they under control?	☐	☐
If not, please specify _____		
6. Are you allergic to any medication or anesthetic? Please list and also list reaction. _____	☐	☐
7. Are you allergic to Latex?	☐	☐
8. Have you been hospitalized in the last 5 years? Please list the reason and when this occurred. _____	☐	☐

(PLEASE SEE OTHER SIDE)

	YES	NO
9. Have you ever had root canal treatment before?	☐	☐
10. Do you need to premedicate prior to dental treatment for any of the following reasons? (please check)	☐	☐

☐ Heart Murmur or MVP ☐ Joint Prosthesis (hip, knee, etc.)

☐ Rheumatic Fever or Rheumatic Heart Disease ☐ Prosthetic Heart Valve

11. Are you pregnant?	☐	☐
12. Are you taking birth control pills?	☐	☐

If the answer is yes, please be advised that taking antibiotics can lessen the effect of the birth control pills.

13. Please list anything else in your medical history of significance _____

_____

14. How do you plan to pay for today's visit? ☐ Cash ☐ Check ☐ Credit Card (MC, VISA or Discover)

Patient's (Parent's) Signature X _____ Date _____

_____ Date _____ _____ Date _____

james g kotapish, jr, dds, ms christopher kayafas, dds, ms

INFORMED CONSENT

Endodontic Treatment (Root Canal Therapy) is usually performed to remove infected or damaged tissue from inside a tooth. After the pulp is removed, the pulp chamber and root canals are cleaned, shaped, and filled. After treatment is completed, the patient will need to have the tooth restored by the patient's dentist, usually with a crown. Endodontic treatment cannot be guaranteed and sometimes, further (surgical) intervention or extraction may be necessary. Other treatment options include: no treatment, waiting for more definitive symptoms to develop, or extraction. Possible complications include: fracture of porcelain on an existing crown, calcified canals, cracked teeth, canals blocked by broken instruments, and pain or swelling. If you have any questions, please ask.

Signature X _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Changes In Medical History (Including Medications)

_____

_____

Signature _____ Date _____

_____

_____

Signature _____ Date _____

_____

_____

Signature _____ Date _____

_____

_____

Signature _____ Date _____