PATIENT INFORMATION

Dr._____ Rev._____ Mr._____ Mrs. _____ Ms. _____

Name_____ Date of Birth Day_____ Month_____ Year_____

Home Address_____ City_____ Postal Code_____

Phone: (____) _____Cell: (____)_____ Email: _____

Occupation _____ Employer _____

Business Address _____ Business Phone (____) _____

Marital Status _____ Name of Spouse/Parent _____

Telephone: (_____)_____

Do you have insurance? Yes_____ No_____

Insurance Information for Yourself

Name of Insurance Company _____ Policy # _____ Certificate ID #_____

Complete If You Have Secondary Insurance

Name of Insurance Company _____ Policy #_____ Certificate ID #_____

Policy Holder _____ Employer _____

Date of Birth Day_____Month_____Year_____

Who Referred You To Our Office?_____

Dentist _____ Phone (_____) _____

Family Doctor _____ Phone (____) _____

MEDICAL HISTORY

Are You In Good Health? YES ☐ NO ☐

Have You Been Treated By a Physician during the Past Two Years YES ☐ NO ☐

Are You Taking Any Medication? YES ☐ NO ☐
Please List
_____

Are You Sensitive or Allergic To:

PENICILLIN YES NO CODEINE YES ☐ NO ☐

LOCAL ANESTHETIC (FREEZING) YES NO

Are You Sensitive or Allergic To Any Other Medications?_____ YES ☐ NO ☐

Have You Ever Had An Unfavourable Reaction Following Dental Treatment? YES ☐ NO ☐

Have You Ever Had Excessive Bleeding Requiring Special treatment? YES ☐ NO ☐

Do You Suffer From TMJ Problems (Jaw Joint) YES ☐ NO ☐

Check Any Of The Following Which You Have Had OR Have Been Diagnosed As Having:

☐ Anemia	☐ Epilepsy	☐ Congestive Heart Failure
☐ Stroke	☐ Heart trouble	☐ Rheumatic Fever
☐ Asthma	☐ Hepatitis	☐ Heart Murmur
☐ AIDS	☐ Tuberculosis	☐ High Blood Pressure
☐ Cancer	☐ Diabetes	☐ Kidney Disease
☐ Arthritis	☐ Neuralgia	☐ Sinus Problems
☐ Angina	☐ Jaundice	☐ Psychiatric Treatment
☐ Thyroid	☐ Depression	☐ Prosthetic Heart Valve
☐ Mitral Valve Prolapse	☐ Hip Replacement	☐ Pacemaker
☐ Knee Replacement		

Have You Had any Other Serious Illness Not Listed Above? _____

Female Patients: Are You Pregnant YES ☐ NO ☐ Which Month? _____

CONSENT FOR ROOT CANAL PROCEDURE, LOCAL ANESTHETIC AND X-RAYS

I, the undersigned being the patient, or guardian of the above named minor patient, consent to the performing of whatever procedure may be mutually decided upon to be necessary or advisable in the opinion of the Doctor. I also give my consent to contact my doctor(s) and or my dentist(s) for clarification of the above information or any information needed to render treatment. **I also understand that upon completion of root canal therapy in the office I must return to my general dentist for the permanent restoration of the tooth. There is a charge of $125.00 for the consultation with the Doctor, which is due after your appointment.**

Signature:_____ Date:_____

YOU MUST RETURN TO YOUR OWN DENTIST TO HAVE THE TOOTH FILLED OR A CROWN PLACED. FAILING TO DO SO MAY RESULT IN THE LOSS OF THE TOOTH. THANK YOU.