PATIENT INFORMATION:

Mr./ Mrs. /Ms./ Dr. / NAME:_____ Birth Date: D_____ M_____Y_____

Home Address: _____ City: _____ Postal Code __ __ __ __ __ __

Tel. Number H:_____B: _____ Cell:_____Occupation _____

Marital Status _____ Do you have dental insurance ? Y / N Name of Insurance Co. _____

Name of INSURED _____ D.O.B. of INSURED: D_____M_____Y_____

GROUP POLICY NUMBER: _____ CERTIFICATE NUMBER:_____

Family Doctor: _____ Your Dentist:__ _____

Who Referred You to Us? _____E Mail Address: _____

Are You in Good Health? Y / N Have you seen a physician with in 2 years for active treatment or check-up? Y / N

Are you Taking any Medication(s)? Y / N If so, please list them:_____

Are you sensitive or ALLERGIC to: (please circle) PENICILLIN CODEINE LOCAL ANESTHETIC

Are you sensitive to / or Allergic to any other Medications? Y / N If so please list:_____

Have you ever had an unfavorable reaction following dental treatment? YES NO

Have you ever Had Excessive Bleeding requiring special treatment? YES NO

Do you suffer from Jaw Joint (TMJ) Problems? YES NO

Circle ANY of the following Which You Have Had OR Have Been Diagnosed As Having:

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

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.

Signature_____ Date_____

YOU MUST RETURN TO YOUR OWN DENTIST TO HAVE THE TOOTH FILLED OR HAVE A CROWN PLACED