Apical Endodontics

Patient's Last Name	First	Middle		Birthdate
Street Address	Apt #	City	State	Zip
Home Phone	Work Phone		Social Security Number	
Driver's License No.			Referring Dentist:	

Dental Insurance (Name & policy #) Spouse's info (If dental insurance applys)

Work Information (Name and address):

MEDICAL HISTORY

Are you presently under the care of a physician?______

If Yes, please give reason(s) for being under a physician's care:________________________

Physician's name_____________________Physician's phone__________________________

Do you require pre-medication with antibiotics before dental treatment?_____Past bisphosphonate use?_____

List all allergies you are aware of:____

List all medications (prescribed or non-prescribed) that you are currently taking:_________________________

PLEASE CIRCLE ANY ILLNESS YOU HAVE EVER HAD:

Alcoholism	Blood Pressure	Epilepsy	HIV/AIDS	Liver	Rheumatic Fever
Allergies	Cancer	Glaucoma	Immunodeficiency	Mental	Sinusitis
Anemia	Diabetes	Head/Neck Injuries	Infectious hepatitis	Migraine	Ulcers
Asthma	Drug Dependency	Heart trouble	Kidney	Respiratory	Vascular

Other:____

Do you wear a heart pacemaker or any other kind of prosthetic appliance?__________How long?__________

Have you ever had any trouble with prolonged bleeding after surgery?________________________________

DENTAL HISTORY

Please circle any condition(s) that applies (apply):

Not having any pain	Pulsating pain	Pain at night	Loose tooth
Cold Sensitivity	Pain in one tooth	Can't sleep	Tooth decay
Heat Sensitivity	Pain in several teeth	Swelling	Cracked tooth
Chewing Sensitivity	Pain in jaw	Fever	New filling/crown
Pressure Sensitivity	Pain next to ear	Abscess	Gum disease

If you are in pain, where do you feel it is coming from?____

How long have you been having symptoms, sensitivity or pain (days, months) ?_________________________

Do you grind or clench your teeth or have you ever had a night guard?______

Have you ever had problems with your temporomandibular joint (TMJ)?_________

Please add any additional comments:____

Signature____Date:_________________