SPECIALIST MEMBER

PRIME ENDODONTICS
YOUR ROOT CANAL SPECIALIST

Patient Information

The following is confidential information and for our records only.

Patient's Name____Birth Date__________
First Last Middle Initial

Home #______________________Work #______________________ Cell #______________________

Home Address ____
Street City State Zip Code

Billing Address____
Street City State Zip Code

Patient's Social Security # ______________________ Employer______________Occupation______________

Referred By/General Dentist ____Phone #______________

Physician's Name ____Phone #______________

Responsible Party or Spouses Information

Name____Birth Date__________
First Last Middle Initial

Social Security #____________________________Employer ____________________Occupation __________

Dental Insurance Information

Patient Insured by__________________________________ Insurance ID #______________________

Do you have dual coverage? Yes___No___ If yes: Insured's Name____________________________________

Insurance Company __________________________ Insurance ID# ______________________________

Permission for Treatment and Responsibility for Payment

I, the undersigned, being the patient or guardian of the above minor patient, consent to the performing of whatever procedure may be decided to be necessary or advisable in the opinion of the doctor, and to the administration of medications deemed indicated including local anesthesia, and antibiotics. No treatment will be instituted until the doctor has explained and discussed treatment alternatives and consequences, and I have decided to begin the recommend treatment.

I understand that root canal therapy is an attempt to retain a tooth which might otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had a root canal therapy may require retreatment, surgery, or even extraction. Present filling, inlays or crowns may need replacement after root canal therapy.

Upon completion of root canal therapy in this office, I am to return to my regular dentist for any necessary permanent restoration.

Prime Endodontics reserves the right to charge $100 fee for missed appointments or cancelations without or 24 hours notice.

I understand that total payment of the fee for dental services performed by Prime Endodontics is my responsibility and not that of the insurance company.

Signature____ Date__________________________

MEDICAL HISTORY

In case of emergency contact: Name ___________________________ Relationship _____________________phone___________________

PHARMACY____PHONE____

Please Check YES or NO

Date of last physical exam: _________________

		YES	NO
1.	Do you have any unhealed injuries, or inflamed areas, growths or sore spots in and around your mouth?	___	___
2.	Has there been a change in your general health within the past year?	___	___
3.	Are you under the care of a physician for a current problem? If yes, please explain: ____	___	___
4.	Have you been hospitalized in the past 5 years? If yes, please explain: ____	___	___
5.	Have you received therapy for alcoholism or drug addiction during the past 5 years?	___	___
6.	Have you ever had an **ADVERSE REACTION (allergic reaction)** to: _ **PENICILLIN** _**NOVACAINE** _ **CODEINE** _**ASPRIN** _**LATEX** any others: _________________		
7.	Is there a condition concerning your health the Doctor should know about? If yes, please explain____	___	___
8.	Have you had abnormal bleeding with previous extractions, surgery, or trauma?	___	___
9.	Have you ever required a blood transfusion?	___	___
10.	Have you ever had chemotherapy and/or radiation for a tumor, growth or other condition?	___	___
11.	Have you ever been tested positively for HIV infection or AIDS? If yes, date diagnosed and the treating Doctor's name: ___________________________________	___	___
12.	Are you required to pre-medicate/take an antibiotic prior to dental treatment (per medical Doctor)?	___	___
13.	Women ONLY---Are you pregnant, or nursing? If yes, please specify ____	___	___
14.	Women ONLY---Are you taking birth control pills? If YES, Be advised that if you take antibiotics, an alternative method of birth control must be used.	___	___

Do you have or had any of the following? Please **check ALL** that apply:

__High Blood Pressure
___Heart Murmur or Prolapsed Valve
___Joint Prosthesis (hip, knee, etc.)
___Rheumatic Fever or Rheumatic Heart Disease
___Congenital Heart Disease
___Cardiovascular Disease: heart attack, stroke or bypass
___Prosthetic Heart Valve
___Blood Disorder (e.g. anemia)
___Venereal Disease
___Asthma
___Chest Pains, or Angina
___Swollen Ankles
___Heart Surgery
___ Delay in Healing
___ Problems w/ Immune System
___Emphysema
___Eye Disease or Glaucoma
___ Temporomandibular Joint Problems (TMJ)
___Sinus Trouble/Hay Fever
___Thyroid Problems
___Diabetes
___Stomach Ulcer
___Hepatitis
___Kidney Problems
___Psychiatric Treatment
___Fainting Spells
___Epilepsy
___Cancer, jaundice, liver disease
___Dialysis
___Cardiac Pacemaker
___Bronchitis, Chronic Cough
___ Herpes/Cold Sores
___ Fibromyalgia
___ Difficult Breathing or other Long Trouble
___Bruise easily
___Ever taken "Fen Phen" Diet pill

15. Are you taking any Herbal Medications i.e. St. John Wart? If yes please list. ____
16. Do you have any disease or condition not listed above? Please list.
____
17. Are you taking any medications or drug? Please list them below:
____

Signature____________________________________ Date____________________ Staff Initials________________
(PATIENT OR PARENT IF PATIENT UNDER 18 YEARS OF AGE)

Medical History Update (for staff use only)

Changes ____

Date ___________________ Staff Initials________________