



Limited to Endodontics

Endodontics and Endodontic Surgery
Est. 1981

Your medical and dental health history are essential for the determination and course of your treatment in our office. It is important that you complete this questionnaire accurately as it will become part of your office record. Be assured that it will be held in the strictest of confidence.

Welcome to our Office

Today's Date _____

Have you been a previous patient here? Yes No

Please print clearly

Dr. Mrs. Mr. Ms. Last name _____ First name _____ Middle Initial ____ Birth Date (Y/M/D) ____/____/____

Home Address _____ Apt. # _____ City _____ Postal Code _____

Home Tel. Number: () _____ Business Tel. Number: () _____ Cell: () _____

Occupation _____ Employer _____ Address _____

Do you have dental insurance? YES NO

Name of Spouse/Parent _____ Business Tel. () _____

Referring Dentist _____ Other Dentists you see _____

Family Physician _____ Tel. Number: () _____

Whom may we thank for referring you to us? _____

HEALTH HISTORY

(PLEASE CIRCLE)

Please circle how you are feeling. I am: RELAXED NERVOUS TERRIFIED

Have you ever had an unfavourable reaction following dental treatment? Please discuss this with the doctor. YES NO

Female patients, are you or could you be pregnant or nursing? If pregnant, which month? YES NO

Check any of the following which you have or have had:

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart trouble/Angina | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stomach ulcer |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Fainting spells |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Nervous disorders | <input type="checkbox"/> Neck injury |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Cortisone treatment | <input type="checkbox"/> Cancer treatment |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Psychiatric treatment | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Migraine/Headaches | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Herpes | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Addictions | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Artificial valve, joint, or prosthesis |
| <input type="checkbox"/> TMJ problems | <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> Blood transfusions |
| <input type="checkbox"/> HIV +/AIDS | <input type="checkbox"/> Cardiac pacemaker | <input type="checkbox"/> Tuberculosis (TB) |

Do you have or have you had any other diseases or medical problems **not** listed on this form? _____

Please list allergies to medications/other substances _____

Please list medications currently being taken (include non-prescription drugs) _____

DENTAL HISTORY

Chief Complaint (reason for presentation) _____

Are you presently in **pain**? YES NO

Are any of your teeth **sensitive** to the following?

Hot Cold Biting Pressure

Sweets Other _____

I would like to discuss options of sedation for my dental treatment

YES NO

I hereby state that the above medical history is, to the best of my knowledge, accurate and complete. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail, If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs or other diagnostic measures appropriate for a thorough evaluation.

Financial Policy: The major objective of our office is to provide you with the highest quality dental care. Our service is based on a friendly, mutual, but businesslike understanding between doctor and patient. We feel that misunderstandings can be minimized if financial policies are made to acquaint you with our policy.

If you have any questions regarding insurance, billing or financial policy feel free to discuss this with our receptionist.

Our fee does not include the cost of a permanent restoration – to be done by your own dentist after your root canal has been completed.

Broken appointments and surgical intervention may constitute an additional fee. All fees are payable upon completion of treatment

Signature _____

Date _____

See reverse

To Dr. _____

CONSENT

I consent to your collection, of any and all personal information about me including my personal health information, and all personal information about any minor of whom I have joint or sole parental custody, and to use such information in any manner or for any purpose whatsoever, but only in the course, of, concerning, or relation to, your dental practice.

I similarly consent to the disclosure to third parties of all such information but only in accordance with the Regulated Health Professions, the Dentistry, and Dental Hygiene Acts of Ontario, and to any insurer or other payment organization who may be responsible for payment of all or a part of any treatment or service you provide.

Date: _____

Patient Signature: _____