Mr. Mrs.

Miss Ms _____ Phone _____ DOB _____
(Last Name) (Given First Name)

Mailing Address _____ City _____ Zip _____

❑ Single ❑ Married ❑ Widow ❑ Minor Patient's Social Security # _____

Patient's Employer _____ Address _____ Bus Phone _____

Spouse/Parent _____ Employer _____ Bus Phone _____

Person Responsible for Account _____ Dental Insurance Co. _____

Person Insured _____ Soc. Sec. # _____ DOB _____

2nd Ins. _____ Insured _____ SS # _____ DOB _____

Name of Closest Relative _____ Phone _____

If You have DENTAL INSURANCE, please sign below.

I authorize release of any information relating to this claim.

I hereby authorize payment directly to Victoria Endodontics of the group insurance benefits otherwise payable to me.

_____
Signed (Patient or Parent if Minor)

Referred by Dr. _____

MEDICAL HISTORY

Circle the answer which applies. If you are uncertain, please mention it to the doctor.

What is your estimation of your health?
Good Fair Poor

Are you Presently under a physician's care?
Yes No

If Yes, what condition is being treated?
_____

Have you been hospitalized in the last 5 years?
Yes No

If Yes, what was the problem? _____
_____

Physician's Name _____

Date of last Physical _____

Have you had abnormal bleeding associated with previous extractions, surgery or trauma? Yes No

Have you had any serious trouble associated with any previous dental treatment? Yes No

If so, explain: _____

Are you **ALLERGIC** or have you reacted adversely to: Please circle or check each line.

Local anesthetics	Yes No	Penicillin	Yes No
Antibiotics	Yes No	Barbiturates, sedatives, or sleeping pills	Yes No
Aspirin	Yes No	Iodine	Yes No
Codeine or other narcotics	Yes No	Latex rubber	Yes No
Other	Yes No	Nickel	Yes No

Have you previously had a Root Canal Treatment? Yes No

What problem brought you to us today? _____

(OVER)

Circle **Y**(es) or **N**(o) for all the following conditions which you have had or have at present:

Abnormal Heart Condition ..... Y ..... N	Lung Disease ..... Y ..... N	AIDS or HIV positive ..... Y ..... N
Heart Murmur ..... Y ..... N	Asthma ..... Y ..... N	Hepatitis ..... Y ..... N
Heart Surgery ..... Y ..... N	Allergies or Hives ..... Y ..... N	Liver Disease ..... Y ..... N
Rheumatic Fever ..... Y ..... N	Diabetes ..... Y ..... N	Addiction (drug, alcohol, gaseous) ..... Y ..... N
High Blood Pressure ..... Y ..... N	Thyroid Disease ..... Y ..... N	Hemophilia ..... Y ..... N
Artificial Joint ..... Y ..... N	Cancer or Tumor ..... Y ..... N	Venereal Disease (Syphilis, Gonorrhea) Y ..... N
Anemia or Blood Disorders ..... Y ..... N	X-Ray, Radium, or Cobalt Treatment .... Y ..... N	Epilepsy or Seizures ..... Y ..... N
Stroke ..... Y ..... N	Glaucoma ..... Y ..... N	Emotional Disease ..... Y ..... N
Pain in Jaw Joints (TMJ) ..... Y ..... N	Sinus Infections ..... Y ..... N	

Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No

_____

(Women) Are you Pregnant? Yes No Are you nursing? Yes No

Are you **TAKING** any of the following drugs?

Antibiotics or sulfa drugs ..... Yes ..... No	Anticoagulants (blood thinners) ..... Yes ..... No
Medicine for high blood pressure ..... Yes ..... No	Cortisone (steroids) ..... Yes ..... No
Tranquilizers ..... Yes ..... No	Antihistamines ..... Yes ..... No
Aspirin ..... Yes ..... No	Insulin, tolbutamide (Orinase) or similar ..... Yes ..... No
Digitalis or drugs for heart trouble ..... Yes ..... No	Nitroglycerin ..... Yes ..... No
Oral Contraceptive or other hormonal therapy ..... Yes ..... No	Other medication ..... Yes ..... No

Please list all the medications you are taking:

_____ _____

_____ _____

_____ _____

To the best of my knowledge, all of the preceding answer are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

INFORMED CONSENT

I understand root canal treatment is a procedure to retain a tooth which may otherwise require extraction. Although Root Canal therapy has a very high degree of success, it is still a biologial prodedure, so it cannot be guaranteed. Occasionally, a tooth which has had Root Canal therapy may require retreatment, surgery, or even extraction.

Although rare, the following complications may occur in endodontic therapy:

Pain and swelling		5%	Damage to an existing filling or crown	1/2%
Fracture of a root	Less than	1%	Over or Underfill or perforation of a root	Less than 5%
Broken instrument	Less than	1%	Adverse reaction to medication	

I understand that only the root canal treatment and possibly a post and buildup is to be performed at this office. The permanent (outside) restoration (filling, inlay, crown, etc.) will be done by my regular dentist.

I also accept full responsibility for the payment of services performed and agree to pay for them in full, AT or BEFORE COMPLETION, unless other specific arrangements are made with the secretary.

Please CIRCLE method of payment other than insurance: Personal checks cash MasterCard VISA Discover

SIGNED _____ DATE _____