Southwest Endodontics

THE FOLLOWING CONFIDENTIAL INFORMATION IS
FOR OUR RECORDS ONLY

Name ..... Spouse's Name .....

Date of Birth ..... Spouse's Date of Birth .....

Social Security No. ..... Social Security No. .....

If a Minor, Parent's Name ..... Marital Status .....

Address ..... Phone (.....) .....

City ..... State ..... Zip ..... Cell .....

Employer .....

Address ..... Phone (.....) ..... Ext: .....

City ..... State ..... Zip ..... Cell .....

Physician ..... Phone (.....) .....

Referring Dentist ..... Phone (.....) .....

Dental Insurance Co. .....

Who is responsible for this account .....

Who may we contact in case of an emergency? Name .....

Address ..... Phone (.....) .....

MEDICAL HISTORY

1. Are you in good health? ..... **YES** **NO**
2. a. Have you been in a hospital or had a serious illness or accident within the past 2 years? ..... **YES** **NO**
   b. If so, what was the problem? .....
3. Are you under the care of a physician? ..... **YES** **NO**
4. Are you allergic to: a. Local Anesthetics ..... **YES** **NO**
   b. Penicillin or other antibiotics? ..... **YES** **NO**
   c. Codeine or other narcotics? ..... **YES** **NO**
   d. Other .....
5. Do you usually pre-medicate yourself for any dental treatments? ..... **YES** **NO**

PLEASE COMPLETE THE FOLLOWING IN FULL (check one)

YES/NO	Angina (Chest Pain)	YES/NO	Abnormal Blood Pressure	YES/NO	Jaundice	YES/NO	Immune Suppressive Disorders
YES/NO	Heart Trouble			YES/NO	Hepatitis		
YES/NO	Heart Murmur	YES/NO	Rheumatic Fever	YES/NO	Tuberculosis	YES/NO	Cancer
YES/NO	Pace Maker	YES/NO	Anemia	YES/NO	Sinus Trouble	YES/NO	Epilepsy
YES/NO	Damaged or Artificial Heart Valves	YES/NO	Kidney Trouble	YES/NO	TMJ	YES/NO	Stomach Ulcers
		YES/NO	Asthma	YES/NO	Aids	YES/NO	Psychiatric Problems
YES/NO	Heart Attack	YES/NO	Diabetes	YES/NO	HIV	YES/NO	Arthritis

If you are presently using medication, please list .....

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

Signature ..... Date .....
Patient or Parent of Minor

WOMEN

6. Are you pregnant? ..... **YES** **NO**
7. Are you nursing? ..... **YES** **NO**