

Medical Alert:

Recall: NA Date:

#	U	/	/	:
#	U	/	/	:
#	U	/	/	:

Last _____ First _____ MI _____ Nickname _____
 Address _____ City _____ Zip _____
 Phone _____ Work _____ Cell _____
 E-mail _____ Birthdate _____ Age _____
 Occupation _____ Employer _____ Hobbies _____
 Soc. Sec.# _____ Sex: M F Single Married Child

_____ # _____
 Rct Retx Sx Rct Retx Sx
 Ex _____ Ex _____
 Tx _____ Tx _____
 R _____ R _____

If insurance subscriber is someone other than you or in addition to you, please fill out the following:

Name _____ Soc. Sec.# _____ DOB _____
 Employer _____ Work Phone _____

_____ # _____
 Rct Retx Sx Rct Retx Sx
 Ex _____ Ex _____
 Tx _____ Tx _____
 R _____ R _____

Insurance information

Dental insurance name _____ Phone# _____ Grp# _____
 2nd Insurance name (if applicable) _____ Phone# _____ Grp# _____

General information

General Dentist _____ Name of Physician/Clinic _____
 Person to call in case of emergency _____ Phone# _____

Medical History

- Are you in good health? Y N
- Please list any medications you are now taking and the reason for taking them: _____

- Are you presently under the care of a physician? Y N If yes, for what condition? _____
- In the last five years have you been: Hospitalized? Y N Had a serious illness? Y N Had a major operation? Y N
 If yes, please explain _____
- Have you ever had any of the following conditions? (Please circle)

Heart Surgery, disease, attack	Heart pacemaker	Hepatitis, Jaundice or Liver Disease	Cold Sores
Angina Pectoris	Artificial joint/prosthesis	Chemotherapy/X-Ray Treatment	Herpes
High/Low blood pressure	Stroke	Lung disease Tuberculosis	Allergies
Rheumatic Fever	Kidney disease	Drug addiction/Alcoholism	Asthma/Hayfever
Congenital Heart Lesions(MVP)	Cancer or tumors	Hemophilia or excessive bleeding	Sinus Trouble
Heart Murmur	Blood transfusion	Psychiatric treatment/Mental disorder	Arthritis
Artificial heart valve	Diabetes	Sexually transmitted disease	
Seizures/Epilepsy	Thyroid disease	AIDS or HIV positive Date tested: _____	
- Have you ever had an allergic or unusual reaction to any of the following medications? (Please circle)

Dental local anesthetics	Barbiturate or tranquilizers	Penicillin or other antibiotics	Latex
Aspirin, acetaminophen or ibuprofen	Codeine or other narcotics	Other _____	
- Women:** Are you pregnant? Y N If yes, how many months? _____ Are you taking birth control pills? Y N
 (If you are taking birth control pills, please read the following: Antibiotics may inactivate birth control medication.
 Therefore if you need to take antibiotics during endodontic treatment additional birth control measures should be taken.)
- Is there anything the dentist should know regarding your medical history that has not been mentioned? Y N
 Please explain _____
- Have you ever had any serious complications involving dental treatment? Y N
 Please explain _____

I, the undersigned, being the patient, parent or guardian of the above minor patient, consent to the performing of whatever procedure may be determined necessary by the Doctor, including the administration of drugs and/or anesthetics. I also understand that upon completion of root canal therapy in the office I will be referred to my dentist for permanent restoration, such as an onlay or crown if needed.

Signed _____ Date: _____