Patient's Last Name First Middle Birthdate

Street Address City State Zip Home Phone Cell Phone Work Phone

Social Security Number: Driver's License Number: Referring Dentist:

Work Name and Address: Dental Insuarnce Name & Policy# Spouse's info (for insurance)

MEDICAL HISTORY

Are you presently under the care of a physician?_____If Yes, please give reason(s) for being under a physician's care:_____Physician's name/phone_____

Is pre-medication with antibiotics required before dental treatment?_____Past bisphosphonate use?_____

List all allergies you are aware of:_____

List all medications:_____

PLEASE CIRCLE ANY ILLNESS YOU HAVE EVER HAD:

Alcoholism	Blood Pressure	Epilepsy	HIV/AIDS	Liver	Rheumatic Fever
Allergies	Cancer	Glaucoma	Immunodeficiency	Mental	Sinusitis
Anemia	Diabetes	Head/Neck Injuries	Infectious hepatitis	Migraine	Ulcers
Asthma	Drug Dependency	Heart trouble	Kidney	Respiratory	Vascular
Cholesterol	Other:_____				

Do you wear a heart pacemaker or any other kind of prosthetic appliance?_____How long?_____

Have you ever had any trouble with prolonged bleeding after surgery?_____

DENTAL HISTORY

Please circle any condition(s) that applies (apply):

No pain	Pulsating pain	Pain at night	Loose tooth	Cold sensitivity
Pain in one tooth	Can't sleep	Tooth decay	Heat Sensitivity	Pain in several teeth
Swelling	Cracked tooth	Chewing Sensitivity	Pain in jaw	Fever
New filling/crown	Pressure Sensitivity	Pain next to ear	Abscess	Gum disease

If you are in pain, where do you feel it is coming from?_____

How long have you been having symptoms, sensitivity or pain (days, weeks, months) ?_____

Do you grind or clench your teeth or have you ever had a night guard?_____ Any TMJ problems?_____

Please add any additional comments:_____

Signature_____Date:_____

***BEYOND THIS POINT: FOR DOCTOR'S USE ONLY:**

Medical History_____

Dental History_____

_____Extraoral exam:_____Intraoral exam:_____

Occlusal exam:_____Angle's classification_____TMJ exam:_____

Circle the appropriate responses:

Pain: No pain + ++ +++ **Location:** Localized diffuse radiating referred

Frequency: constant intermittent spontaneous provoked momentary lingering

Type: pulsating sharp dull other_____ **Pain increases with:** cold hot chewing manipulation sweets other_____

Clinical Testings: **PROBINGS:**

Tooth	Cold	Heat	Perc	Palp	Mob	Caries	Furc	Fracture	Sinus Tract	MB	B	DB	DL	L	ML

Other Findings:_____Pulpal diagnosis_____Periapical diagnosis_____

Treatment plan_____Alternative options_____

Prognosis: Favorable Fair Guarded Poor

The following have been explained to the patient: exam findings, periodontal status, crown/root fractures, treatment plan & options, prognosis, restoration(s) and consent form. ENDODONTIST'S INITIALS_____