

SOUTHCOAST
Endodontics
Comprehensive care for a lifetime of natural smiles.

Name (First) _____ (MI) _____ (Last) _____ Date _____
Address _____ (street) Phone (home) _____
_____ (city,state,zip) (work) _____
Email _____ (mobile) _____
Date of Birth ___/___/___ Social Security # _____ Gender M / F Height _____ Weight _____
Marital Status: S / M / W / D Spouse's Name _____
Emergency Contact Information: Name _____ Phone _____
Address _____ Relationship to patient _____
Name of parent or guardian if patient is a child _____

Name of General Dentist _____ Referred by _____
Other Specialists _____ Physician's Name _____
How did you hear of our practice? _____ Last Physical Exam Date ___/___/___

Dental Insurance _____ ID# _____ Group# _____
Insured _____ DOB ___/___/___ Relationship: Self / Spouse / Parent (Guardian)
Second Carrier _____ ID# _____ Group# _____
Insured _____ DOB ___/___/___ Relationship: Self / Spouse / Parent (Guardian)

PLEASE PROVIDE YOUR CARD(S) SO THAT WE CAN MAKE A COPY.

Responsible Party Name _____ Relationship to Patient _____
Address (if different than above) _____
Employer Name and Address _____

PLEASE NOTE: IF ANNUAL MAXIMUM IS REACHED, NO ADJUSTMENTS WILL BE MADE. PATIENT IS RESPONSIBLE FOR REMAINING BALANCE IN FULL. A \$50 FEE WILL BE APPLIED FOR ANY RETURNED CHECK.

Please answer the following questions, YES OR NO, if you have or have had any of the following:

1. Are you in good health? YES NO
2. Have there been any changes in your general health within the past year? YES NO
3. Are you now under the care of a physician? YES NO

If so, what is the condition being treated? _____

4. Have you had any serious illness or operation requiring hospitalization in the last 5 years? YES NO

If so, please explain _____

5. Have you ever suffered from alcoholism or drug addiction? YES NO

6. Do you have or have you had any of the following diseases or problems?

a. Rheumatic fever or rheumatic heart disease YES NO

b. Congenital heart lesions YES NO

c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) YES NO

d. Do you have cardiac pacemaker or heart valve? YES NO

e. Do you have any hip or knee joint prosthesis? YES NO

f. Allergy YES NO

g. Asthma, hay fever or sinus trouble (please circle all that apply) YES NO

h. Hives or skin rash YES NO

i. Fainting spells or seizures YES NO

j. Diabetes YES NO

k. Hepatitis, jaundice or liver disease YES NO

l. Arthritis YES NO

m. Inflammatory rheumatism (painful swollen joints) YES NO

n. Stomach ulcers YES NO

o. Kidney trouble YES NO

p. Tuberculosis YES NO

q. Low blood pressure YES NO

r. AIDS or ARC YES NO

s. Reflux, ulcerative colitis or Crohn's disease YES NO

7. Have you had abnormal bleeding associated with previous extractions, surgery or trauma?

YES NO

Have you ever required a blood transfusion? YES NO

If so, explain the circumstances _____

8. Do you have any blood disorders such as anemia? YES NO

9. Have you had surgery or X-ray treatment for a tumor, growth or other condition of your head or neck? YES NO

10. Please list medications (include daily dose) _____

11. **DO YOU REQUIRE ANTIBIOTIC PROPHYLAXIS PRIOR TO ANY DENTAL TREATMENT?** YES NO

12. Are you taking any of the following?

a. Antibiotics or sulfa drugs YES NO

b. Anticoagulants (blood thinners) or medication for high blood pressure YES NO

- | | | |
|--|-----|----|
| c. Cortisone (steroids) | YES | NO |
| d. Antidepressants | YES | NO |
| e. Antihistamines | YES | NO |
| f. Aspirin | YES | NO |
| g. Insulin, Tolbutamide (Orinase®) or similar drug | YES | NO |
| h. Digitalis or drugs for heart trouble | YES | NO |
| i. Nitroglycerin | YES | NO |
| j. Oral contraceptives or other hormone therapy | YES | NO |
| k. Other _____ | | |

Antibiotics may alter the effectiveness of oral contraceptives. Please consult with your physician for recommendations regarding alternative methods of birth control while taking antibiotics.

13. Are you allergic or have you reacted adversely to any medication or latex? YES NO
If so, please specify _____

14. Have you had any serious trouble associated with any previous dental treatment? YES NO
 If so, please explain _____

15. Do you have any disease, condition or problem not listed above that you think we should know about? YES NO
 If so, please explain _____

16. Are you taking (or have you taken in the past) any form of bisphosphonate (example: FOSAMAX®)? YES NO

WOMEN

17. Are you pregnant? YES NO

18. Are you nursing? YES NO

INFORMED CONSENT

I understand root canal treatment is a procedure to retain a tooth that may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Occasionally, a tooth that has had root canal therapy may require retreatment, surgery or even extraction. I also understand that only the root canal treatment is to be performed at this office. The permanent (outside) restoration (filling, onlay, crown, etc.) will be done by my regular dentist. I understand I have the right to refuse treatment and that I am responsible if I terminate treatment against doctor's advice. I give permission to Southcoast Endodontics to perform procedures, including the giving of local anesthetics or taking of radiographs that may be necessary for my dental treatment.

I also acknowledge full responsibility for the payment of such services and agree to pay for them in full AT OR BEFORE COMPLETION unless other specific arrangements are made with the office.

I authorize my insurance carrier to issue the dental benefits of my plan directly to this dental office. I also authorize release of any information necessary to process dental insurance.

 Signature of Patient Date: _____

 Signature of Dentist Date: _____