West Michigan Endodontists, PC

PERSONAL INFORMATION

Last First Middle

Name: Dr Mr Mrs Ms _____ **Date** _____

Address: _____ **City** _____ **State** _____ **Zip** _____

Phone Numbers: Home _____ **Work** _____ **Cell** _____

Gender: F or M **Birthdate** _____ **Person Responsible for Bill** _____

Employer: _____ **General Dentist** _____ **Physician** _____

List any immediate family members treated at this office: _____

Emergency Contact: _____ **Phone Number:** _____

PERSONAL HEALTH INFORMATION

	CIRCLE ONE		
Are you currently under the care of a physician?	Yes	No	If so, what are you being treated for? _____
Have you been hospitalized in the past five years?	Yes	No	If so, please describe: _____
Do you have unhealed sores in or around your mouth?	Yes	No	If so, describe where: _____
Have you been advised by your physician to premedicate with an antibiotic before ALL dental appointments?	Yes	No	If so, what and how much did you take today? _____
Do you have an artificial/prosthetic joint?	Yes	No	If so, describe where and when: _____
Do you have a heart murmur, valve replacement, MVP or a vascular graft?	Yes	No	If so, which one: _____
Have you ever taken Bisphosphonate medications (examples are: Actonel, Fosamax, or Zometa)?	Yes	No	If so, what did you take? And when? _____

HEALTH HISTORY

Have you had a history of any of the following conditions:

	CIRCLE ONE	
Heart condition	Y	N
High Blood Pressure	Y	N
Respiratory	Y	N
Rheumatic Fever	Y	N
Vascular/Circulatory	Y	N
Immunocompromised	Y	N
Anemia/Bleeding	Y	N
Diabetes (Type I/Type II)	Y	N
Kidney/Dialysis	Y	N
Cold Sores	Y	N
Thyroid	Y	N
Hepatitis	Y	N
Tuberculosis	Y	N
Arthritis	Y	N
Ulcers/Digestive	Y	N
Migraines/Headaches	Y	N
Epilepsy/Fainting	Y	N
Glaucoma/Visual	Y	N
Mental/Neurological	Y	N
Tumor/Neoplasm	Y	N
Alcoholism/Addiction	Y	N
Infectious Diseases	Y	N
Venereal Diseases	Y	N
HIV virus or AIDS	Y	N
TMJ or TMD	Y	N
Currently Pregnant/Nursing	Y	N

Other (please list): _____

Do you have any allergies to:

	CIRCLE ONE	
Penicillin	Y	N
Antibiotics	Y	N
Aspirin	Y	N
Tylenol	Y	N
Codeine	Y	N
Narcotics	Y	N
Local Anesthetic	Y	N
Latex	Y	N
Bananas/Nuts/Kiwi	Y	N

Other (please list): _____

Are you currently taking any medications: PLEASE LIST ALL MEDICATIONS

	CIRCLE ONE		
Antibiotics	Y	N	_____
Pain Medication	Y	N	_____
Heart Medication	Y	N	_____
Aspirin	Y	N	_____
Cortisone/Steroid	Y	N	_____
Blood Thinner	Y	N	_____
Blood Pressure	Y	N	_____
Birth Control	Y	N	_____
Insulin	Y	N	_____
Thyroid	Y	N	_____
Hormone	Y	N	_____

Other (please list) _____

PATIENT CONSENT

I, the undersigned, consent to the performing of an endodontic examination and endodontic procedure(s) that may be desired, necessary, or advisable after reviewing the treatment options with the doctor. I have provided an accurate and complete medical and personal history including all current medications and allergies. **I also understand that I am to promptly return to my dentist for a permanent restoration of the treated teeth.**

Patient Signature _____ **Date:** _____

(Parent or Guardian if Minor)

Doctor's Notes - _____