PATIENT INTRODUCTION

Welcome to our office. Please complete the following confidential questionnaire.

Date ________________

ADULT PATIENTS

Name ______________________________ Age________ Date of Birth________________ Sex____________

Home Address: Street ______________________________ City________________ State________ Zip__________ Phone____________

Business Address: Street ______________________________ City________________ State________ Zip__________ Phone____________

Social Security No.: ____________________ Occupation:____________________ Employer:____________________

Single ________ Married__________ Spouse's Name____________________ Spousee's Employer__________________ Phone ____________

Separated ________ Widow____________

CHILD AND ADOLESCENT PATIENTS

Child's Name ______________________________ Age________ Date of Birth________________ Sex____________

Home Address:______________________________ City________________ State________ Zip__________ Phone____________

Father's Name ____________________ Address ______________ City______________ State ______ Zip ________ Phone__________

Date of Bith ____________________ Social Security No. ________________ Employer ________________________ Phone____________

Mother's Name____________________ Address ______________ City______________ State ______ Zip ________ Phone__________

Date of Bith ____________________ Social Security No. ________________ Employer ________________________ Phone____________

ACCOUNT INFORMATION

Preferred Method of Payment: ____________Cash ____________Check ____________ Mastercard/Visa

DENTAL INSURANCE INFORMATION

Name of Insured: ____

Social Security #:____ Date of Birth________________

Primary Dental Insurance Carrier Co.: ________________________ Phone:______________ Employer: ______________

Group # ____ Effective Date: ______________

GETTING TO KNOW YOU

Person to Contact For Emergency: ____

Relationship: ____ Phone:______________

Have we treated a member of your Family or Friends at our office? ______________ If So, Who?____________________

Is there anything special you would like us to know about you? ________________________________

Who may we thank for referring you to our office? ________________________________

Who is your general/family dentist? ________________________________

PLEASE CONTINUE ON REVERSE SIDE WITH THE PATIENT'S MEDICAL HEALTH HISTORY

MEDICAL HEALTH HISTORY

Physician's Name ______________________ Address ______________________________ Phone ____________________

Do you have, or have you ever had, any of the following? Please Circle

Heart Disease
High Blood Pressure
Low Blood Pressure
Heart Murmur
Mitral Valve Prolapse
Heart Valve Replacement
Pacemaker
A Stroke

Bleeding Problem
Blood Transfusions
Blood Disorders, Anemia
Rheumatic Fever
Tuberculosis
Stomach or Intestinal Ulcers
Organ Transplant
Epilepsy

Hepatitis (ABC)
HIV
Radiation Treatment
Arthritis
Liver or Kidney Disease
Drug Abuse

Diabetes
Asthma
Lung Disease
Chemotherapy
Thyroid Disease
Glaucoma
Artificial Joint

Do you have any disease, condition, or problem not listed above? ☐ YES ☐ NO (if YES, Please explain)

____

____

Have you been hospitalized and / or had surgery within the last five years ? ☐ YES ☐ NO (if YES, Please explain)

____

____

Please list any medications you are presently taking: ____

____

____

____

Are you allergic or sensitive to any of the following medications: Please circle

Penicillins
Erythromycins
Tetracyclines
Codeine

Aspirin
Tylenol
Demerol

Carbocaine
Xylocaine
Novocaine
Valium

Percodan
Latex

List others you are allergic or sensitive to: ____

____

WOMEN: Are you pregnant? ☐ YES ☐ NO Delivery Date? ______________________

Are you nursing? ☐ YES ☐ NO When do you expect to stop nursing? ______________

Taking Birth Control Pills? ☐ YES ☐ NO

CONSENT

I understand endodontic treatment is a procedure to retain a tooth which may otherwise require extraction. Although endodontic therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Ocassionally, a tooth which has had endodontic therapy may require retreatment, surgery, loss of dental prosthesis or extraction.

I also understand that only the endodontic treatment is to be performed at this office. Ther permanent (outside) restoration (filling, onlay, crown, bridge, etc.) will be done by my regular dentist.

Some risks associated with the procedures include fracture or loss of the tooth, continued pain, infection, swelling, trismus (restricted jaw opening), discoloration, difficulty with diagnosis, especially if more than one tooth needs treatment at the same time, paresthesia (a numbness, tingling) separated instruments, overextension of filling materials, inability to negotiate all canals, and damage to your present restoration.

I have read the preceding risks that may occur in connection with this procedure, I believe I have been given and understand sufficient information to give my consent to the above treatment, and for Dr. John M. Gilmer to administer anesthetics and medications he deems necessary for the care of the patient named above.

I authorize release of any information relating to my dental healthcare.

PATIENT/LEGALLY RESPONSIBLE PERSON X ______________________________

Your total well-being is our primary concern.