ROOT CANALS ROCK
ENDODONTICS

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WELCOME TO OUR PRACTICE!

To help us provide you with the best possible care, please complete the following confidential information.

Date: _____ Patient's Legal Name: _____
Last First Middle Initial

Preferred Name/Prefix: _____ Gender: _____ Marital Status: ❑Single ❑Married ❑Divorced ❑Other
Dr. Mr. Mrs. Ms.

Birth Date: _____ Social Security #: _____ Email: _____

Home Address: _____
Street # City State Zip Code

Postal Address: _____
Street # City State Zip Code

Home #: (_____) _____ Cell #: (_____) _____ Work #: (_____) _____

Permission to Contact by: ❑Phone Call ❑Text Message ❑Email ❑Work Phone (Please circle your preferred contact)

Employer: _____ Occupation: _____ ❑Full-Time ❑Part-Time

School: _____ ❑Full-Time ❑Part-Time

Whom may we thank for referring you? _____

How did you hear about us? ❑Internet ❑Insurance Co. ❑Other _____

Emergency Contact Name: _____ Relationship: _____

Home #: (_____) _____ Cell #: (_____) _____ Work #: (_____) _____

Person Responsible for Account: _____ Relationship: _____

Billing Address (if different than above): _____
Street # City State Zip Code

Birth Date: _____ Social Security #: _____ Employer: _____

Home #: (_____) _____ Cell #: (_____) _____ Work #: (_____) _____

DENTAL INSURANCE

To ensure the submission and processing of insurance claims, please provide all requested information below.

Dental Insurance Company: _____ Phone #: (_____) _____

Name of Insured: _____ Birth Date: _____ Social Security #: _____

Employer: _____ Group/Plan ID: _____ Subscriber ID: _____

Claims Address: _____
Street # City State Zip Code

Patient First Name:_____ Last Name: _____ DOB: _____

Medical History

Please read each question carefully and answer all questions on each page.

1.) Have you been under the care of a Medical Doctor during the past three years? ❑Yes ❑No

If yes, what for? _____

Physician's Name: _____ Specialty: _____

Phone #: (_____) _____ Address: _____

Physician's Name: _____ Specialty: _____

Phone #: (_____) _____ Address: _____

2.) Are you taking any anticoagulants (blood thinners)? **(i.e., Coumadin, Xarelto, Eliquis, Warfarin, Rivaroxaban)** ❑Yes ❑No

If yes, please explain: _____

3.) Are you currently taking, or have you ever taken any medication(s) for Osteopenia or Osteoporosis? ❑Yes ❑No

(i.e., Actonel, Aredia, Boniva, Evista, Fosamax, Zometa) ❑ Pill ❑ IV Infusion ❑ Injection

If yes, please explain: _____

4.) Have you ever had any surgical procedure(s) for joint replacement? ❑Yes ❑No

If yes, please explain: _____

5.) Have you ever had any surgical procedure(s) for heart valve repair or heart valve replacement? ❑Yes ❑No

If yes, please explain: _____

6.) Please list all other surgeries and/or hospitalizations: _____

_____

7.) Are you taking any medications (over the counter, prescriptions, herbs, and supplements)? ❑Yes ❑No

(Please include Aspirin)

Medication	**Dosage**	**Frequency**	**Medication**	**Dosage**	**Frequency**
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

8.) Please provide your preferred pharmacy: _____

Name of Pharmacy **Location** **Phone #**

9.) Are you allergic to or have you reacted adversely to any of the following? (**Please circle all the apply)** ❑Yes ❑No

Aspirin	Codeine	Valium	Penicillin	Other Antibiotics	Eggs
Motrin	Sulfa Drugs	Sleeping Pills	Tetracycline	Bleach	Soy
Tylenol	Local Anesthetics	Sedative/Tranquilizer	Erythromycin	Novocaine	Latex
Ibuprofen	Antihistamines	Iodine	Doxycycline	Local Anesthetics	Other

10.) Are you aware of being allergic to any other medications, substances, or foods? ❑Yes ❑No

Please list **all allergies with occurring reaction**: _____

_____

Patient First Name:_____ Last Name: _____ DOB: _____

11.) Indicate which of the following you have had or currently have. **Please review thoroughly and check all that apply:**

- ❑ Artificial Heart Valve/Stent
- ❑ Bacterial Endocarditis
- ❑ Blood Thinners
- ❑ Chest Pain/Angina
- ❑ Congenital Heart Disease
- ❑ Heart Disease/Attack
- ❑ Heart Murmur
- ❑ High Blood Pressure
- ❑ Irregular Heartbeat
- ❑ Mitral Valve Prolapse
- ❑ Open Heart Surgery
- ❑ Pacemaker
- ❑ Rheumatic Fever
- ❑ Stroke
- ❑ Blood Transfusions
- ❑ Bruise/Bleed Easily
- ❑ Clotting Deficiencies
- ❑ Diabetes/Type: _____
- ❑ Hepatitis/Type: _____
- ❑ High Cholesterol
- ❑ Kidney Disease/Problems
- ❑ Liver Disease
- ❑ Low Blood Sugar
- ❑ Organ Transplant
  Type/Date: _____
- ❑ Sickle Cell Disease
- ❑ Thyroid Disease/Problems
- ❑ Arthritis/Rheumatism
- ❑ Artificial Joints/Prosthetics
  Type/Date: _____
- ❑ Fibromyalgia
- ❑ Connective Tissue Disorder
- ❑ Osteoporosis
- ❑ Bloating
- ❑ Constipation
- ❑ Diarrhea
- ❑ Heart Burn/Acid Reflux/GERD
- ❑ Asthma
- ❑ COPD
- ❑ Emphysema
- ❑ Seasonal Allergies (Hay Fever)
- ❑ Sinus Problems/Infection
- ❑ Sleep Apnea
- ❑ Tuberculosis
- ❑ Caffeine Dependency
- ❑ Chronic Pain
  Where: _____
- ❑ Depression
- ❑ Emotional Problems
- ❑ Epilepsy/Convulsions/Seizures
- ❑ Excessive Dental Fear
- ❑ Frequent headaches
  Frequency: _____
- ❑ Glaucoma
- ❑ Nervousness /Anxiousness
- ❑ Neurological Disorder
- ❑ Psychological Care
- ❑ Wear Contact Lenses
- ❑ Wear Glasses
- ❑ Wear Hearing Aids
- ❑ Cortisone Injection
- ❑ Swollen Ankles

❑ Cancer If yes: ❑ Active ❑ In Remission ❑ Cured Treatment: ❑ Chemotherapy ❑ Radiation
Type: _____ Date of Diagnosis: _____ Last Treatment Date: _____

❑ Exposed to, treated for, or diagnosed with HIV/AIDS? Diagnosis Date: _____ Last Treatment Date: _____

❑ Sexually Transmitted Disease/Infection (please list): _____

❑ Use tobacco or vape If yes, please list type/ frequency: _____

❑ Consume alcoholic beverages If yes, please list type/frequency: _____

❑ Use marijuana (recreational or medicinal) If yes, please list type/frequency: _____

❑ Use any other illicit drugs or narcotics If yes, please list type/frequency: _____

❑ None of the above apply

12.) Do you have, or have you had, any other serious illness, disease, condition, or problem not listed? ❑Yes ❑No

If yes, please explain: _____

13.) Are you pregnant/possibly pregnant? ❑Yes ❑No If yes, how many months: _____ Are you nursing? ❑Yes ❑No

14.) Are you taking birth control pills? ❑Yes ❑No

Patient First Name:_____ Last Name: _____ DOB: _____

Dental History

Please list reason(s) for appointment, chief dental/oral concern: _____

_____

_____

1.) What is the name of your current/previous general dentist? _____

Please provide phone number and location: _____

2.) Have you been advised to take antibiotic pre-medication prior to dental treatment? ❑Yes ❑No

If yes, with whom and when: _____

3.) Have you had any prior orthodontic treatment? ❑Yes ❑No

If yes, please describe when and what was done: _____

Please provide orthodontist's name & location: _____

4.) Indicate which of the following you have had or currently have. **Please check all that apply:**

- ❑ Cold Sensitivity
- ❑ Heat Sensitivity
- ❑ Aching/Throbbing Pain
- ❑ Sharp/Shooting Pain
- ❑ Swelling
- ❑ Other

I understand that the information provided above is necessary to ensure that I receive dental care in a safe and efficient manner. I confirm that I have answered all questions in the medical and dental history section to the best of my knowledge and will notify my treating doctor or a staff member of any changes to my health or medications. I acknowledge that I have been given the opportunity to review the office policies and consent for treatment, and I have had the chance to ask any questions before signing below. By signing, I authorize the use of my initials and signature on the completed intake forms, office policies, and consent for treatment.

Please initial all that apply:

- _____ Financial Policy
- _____ Cancellation Policy
- _____ HIPAA Consent
- _____ Notice of Privacy Practices
- _____ Consent for Root Canal Treatment
- _____ Consent for Endodontic Surgery

_____

Signature of patient/guardian Date

This copy of signature is valid as the original.
Signature on file is valid indefinitely.

Medical Alert (*Office use*) _____

_____

_____

_____

_____