Houston Endodontic Specialists, LLP
Patient Medical History

Dr., Mr., Mrs., Ms., Miss. _____ Today's Date_____

Home #_____ Cell # _____ Email _____

Address _____ City _____ ST _____ Zip _____

Social Security #_____ TX Drivers License #_____ Date of Birth _____

Person Financially Responsible for Account _____ Relationship to Patient _____

Patient's Employer _____ Address _____ Work # _____

Spouse's Employer _____ Address _____ Work # _____

Emergency Contact _____ Phone # _____ Referring Dentist _____

Yes No 1. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If, yes, explain.

_____

Yes No 2. Has there been any change in your general health within the past year? If yes, explain.

_____

Yes No 3. Are you under the care of a physician fora current problem? If yes, explain.

_____

Yes No 4. Have you been hospitalized within the past 5 years? Please specify.

_____

Yes No 5. Have you received therapy for alcoholism or drug addiction during the past 5 years?

Yes No 6. Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetics/antibiotics/medications?

_____

Yes No 7. Is there any condition concerning your health that the doctor should be told?

_____

Yes No 8. Do you wish to speak to the doctor privately about anything?

_____

Yes No 9. Have you had abnormal bleeding with previous extractions, surgery, or trauma?

_____

Yes No 10. Have you ever required a blood transfusion?

_____

Yes No 11. Have you ever had radiation for any condition?

_____

Yes No 12. Have you ever tested positive for HIV infection or AIDS? If so, state the date diagnosed and treating Doctor.

_____

Yes No 13. Are you required to take antibiotics prior to dental treatment?

14. Do you have, or have you had any of the following?

_____ High blood pressure	Sinus trouble
_____ Heart murmur or prolapsed valve	Thyroid problems
_____ Joint Prosthesis (hip, knee, etc.)	Diabetes
_____ Rheumatic fever or rheumatic-heart disease	Stomach ulcers, colitis
_____ Congenital heart disease	Hepatitis, jaundice, liver disease
_____ Cardiovascular disease: heart attack, stroke or bypass	Kidney problems
_____ Prosthetic heart valve	Psychiatric treatment
_____ Blood Disorder (e.g. anemia)	Fainting spells or seizures
_____ Venereal disease	Epilepsy
_____ Asthma	Cancer
Allergy to latex	Temporomandibular joint problems (TMJ)
_____ Low blood pressure	Low blood sugar
_____ Chest pain, angina	Dialysis
_____ Swollen ankles, arthritis or joint disease	Irregular heartbeat
_____ Cardiac pacemaker	Contagious diseases
_____ Heart Surgery	_____ Bronchitis, chronic cough
__Delay in Healing	Hay fever or Sinus problems
_____ Tuberculosis	Problems with the immune system
Emphysema	Difficult breathing or other lung trouble
X- Ray treatment or chemotherapy	Chronic fatigue or night sweats
On a diet	History of drug abuse
History of alcohol abuse	Wear contact lenses
Eye disease or glaucoma	Bruise easily
Infectious mononucleosis	Gallbladder trouble

Yes No 15. Are you talking any herbal medicine (i.e., ST. John's Wort)?

Yes No 16. Have you ever taken the "fen-phen" diet?

Yes No 17, Do you have any disease, condition or problem not listed above? Specify

_____

Yes No 18. Are you taking bisphosphonates now or have you ever taken them in the past (Fosamax)?

Yes No 19. Are you taking any medications or drugs? If yes, please list them below.

_____

_____

Yes No 20. Woman only: Are you pregnant, nursing, or on birth control oils? Please circle those that apply.

Physicians Name _____Physicians Phone # _____

Office Policy Agreement

At the outset, we will try to advise you that the expected outcome (prognosis), the number of appointments anticipated and what you may reasonably expect from the treatment.

The problem of missed appointments hurts everyone. Firstly and most importantly, it delays and may prevent proper treatment of your root canal. Secondly, by reserving your appointment time, others in need of treatment must be delayed or turned away. Unfortunately, if you fail to appear for your scheduled appointment, there will be a rescheduling charge of $35.00.

Dental Insurance

For patient's fortunate enough to have dental insurance, we will assist in filing your primary claim. In some cases our office will accept your insurance benefits as a partial payment for your dental care; however, you will be required to make a partial payment at the time services are rendered. Since insurance benefits differ according to your contract, you will be responsible for the charges not covered by your plan contract.

Informed Consent

I understand that the 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 a biological procedure so it cannot be guaranteed. Occasionally a tooth, which has had Root Canal therapy, may require retreatment, surgery, or even extraction. i also understand that the permanent outside restoration (crown) will be done by my regular dentist.

Although rare, the following complications may occur in the endodontic therapy in the following percentages: Pain and swelling 5%, damage to the existing crown or filling Y2 % fracture of a root is less than 1%, fracture of a fine instrument in the root canal 1%, overfill, under fill or perforation of a root less than 5%.

I acknowledged that the answers to the health questionnaire are true and correct and that I will inform the Endodontist of any change in my health or medications.

I also acknowledge full responsibility for payment of services rendered and agree to pay them in full, at or before completion of treatment, unless other specific arrangements are made with the secretary. There will be a service charge of 2.5% interest per month on account balances over 31 days past due. If you have dental insurance, the service charge will begin four weeks after we submit your claim.

Patient Signature _____Date _____

Or Parent, if a minor patient _____