Endodontic Specialists

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DIPLOMATE, American Board of Endodontics
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Abby Yavorek, DMD, MS

Please check any of the following you have currently or have had in the past

☐ Heart Failure	☐ Shortness of Breath	☐ HIV Positive/AIDS	☐ Long-term Steroid Use
☐ Heart Disease/Attack	☐ Emphysema	☐ Hepatitis A	☐ Kidney Problems
☐ Chest Pains	☐ Cough	☐ Hepatitis B/C	☐ Thyroid Disease
☐ High Blood Pressure	☐ Tuberculosis	☐ Liver Disease	☐ Stomach Ulcers
☐ Heart Murmur	☐ Asthma (Rescue Inhaler: Y/N)	☐ Sexually Transmitted Dis.	☐ Osteoporosis
☐ Mitral Valve Prolapse	☐ Seasonal Allergies	☐ Cold Sore/Blister	☐ Jaw/TMJ Issues
☐ Congenital Heart Problem	☐ Fainting/Dizziness	☐ Bleeding Disorder	☐ Arthritis
☐ Artificial Heart Valve	☐ Tobacco Use	☐ Blood Transfusion	☐ Artificial Joint
☐ Heart Pacemaker	☐ Drug Use/Addiction	☐ Sickle Cell Disorder	Date:_____
☐ Stroke	☐ Diabetes	☐ Cancer/Tumor	☐ Drug Use/Addiction
☐ Epilepsy/Seizures	☐ Glaucoma	☐ Radiation Therapy	☐ Psychiatric Care

Who is your general dentist? _____

Are you under the care of other dental specialists such as a periodontist, oral surgeon, or orthodontist?

Please list: _____

Please check all that apply:

- ☐ I currently or previously have had habits of clenching or grinding
- ☐ I currently use a night guard while sleeping
- ☐ I have had problems with dental anesthetic in the past

  If yes, please explain _____
- ☐ I have had previous orthodontic treatment (Date completed: _____)
- ☐ I have had previous dental trauma (Date: _____)

I, the undersigned, affirm the information above is accurate and complete to the best of my knowledge. I will not hold Dr. Barr, Dr. Spencer, Dr. Yavorek or any member of the office staff responsible for problems arising from errors or omissions that I made in the completion of this form. I consent to any advisable and necessary endodontic therapy to be administered by Dr. Barr, Dr. Spencer, Dr. Yavorek and staff for diagnostic purposes or dental treatment.

_____

Patient's (or Parent/Legal Guardian) Signature **Date**