Endodontic Specialists

Jessica L. Barr, DDS, MS, PA
DIPLOMATE, American Board of Endodontics
David L. Spencer, DDS, MS, PLLC
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Patient Name_____Date of Birth_____

Address_____City_____State_____Zip_____

Phone Numbers: Home_____ Work _____Mobile_____

Current or previous occupation _____ Retired? Y / N Employer _____

Spouse / Partner's Name_____ Date of Birth_____ Employer _____

Emergency Contact_____Phone Number_____Relationship_____

Who, if anyone, may we speak to regarding your endodontic care?_____

Please check all that apply:

☐ I am or have been under the care of a medical doctor within the last two years

Reason for medical care _____Physician_____

☐ I have an allergy to any of the following (please list reactions)

☐ Latex Reaction:_____

☐ Bleach Reaction:_____

☐ Drugs or Medications:
1. _____ Reaction:_____
2. _____ Reaction:_____
3. _____ Reaction:_____

☐ I am currently pregnant (If yes, how many weeks): _____

☐ A physician has recommended I usually take antibiotics before routine dental appointments

☐ I currently or previously have taken bisphosphonate medications or other medications that can affect bone (i.e., Actonel, Fosamax, XGeva, or Prolia) within the past 12 years

☐ I have had radiation therapy to the head/neck region (Reason/Area): _____

Please list all medications you are currently taking with dosages:

_____

_____

_____

_____

☐ I am attaching a separate list of medications or medical concerns/procedures (we are happy to make a copy if needed)

Note: Antibiotics may render birth control pills ineffective. An alternative form of birth control is advised.
Recreational drugs/alcohol may interact with medications used during the dental procedure. Please inform your doctor if this is a consideration.

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

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

  Date:_____
- ☐ Psychiatric Care

Who is your general dentist? _____

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

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**