



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)

<input type="checkbox"/> Latex	Reaction: _____
<input type="checkbox"/> Bleach	Reaction: _____
<input type="checkbox"/> 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)



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

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

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**