Endodontic Specialists

Jessica Barr, DDS, MS, PA
Diplomate, American Board of Endodontics
David Spencer, DDS, MS, PLLC

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
- ☐ Rheumatic Fever
- ☐ Congenital Heart Problem
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Artificial Heart Valve
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Osteoporosis
- ☐ Artificial Joint
- ☐ Arthritis
- ☐ Kidney Problems
- ☐ Shortness of Breath
- ☐ Emphysema
- ☐ Cough
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Hay Fever
- ☐ Allergies/Hives
- ☐ Tobacco Use
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Cancer/Tumor
- ☐ X-ray/Cobalt Treatment
- ☐ Chemotherapy
- ☐ Leukemia
- ☐ Steroid Medication
- ☐ Epilepsy/Seizures
- ☐ Jaw Pain/TMJ Problems
- ☐ HIV Positive/AIDS
- ☐ Hepatitis A
- ☐ Hepatitis B/C
- ☐ Liver Disease
- ☐ Herpes/Venereal Disease
- ☐ Blood Transfusion
- ☐ Drug Use/Addiction
- ☐ Hemophilia
- ☐ Sickle Cell Disorder
- ☐ Bleeding Disorder
- ☐ Anemia
- ☐ Fainting/Dizziness
- ☐ Nervousness
- ☐ Glaucoma
- ☐ Psychiatric Care
- ☐ Cold Sore/Blisters
- ☐ Ulcers
- ☐ Currently taking or have you previously taken bisphosphonate medications such as Actonel®, Boniva®, Fosamax®, or Zometa® within the past 12 years

Consent Statement

I, the undersigned, affirm that the information above is accurate and complete to the best of my knowledge. I will not hold Dr. Barr, Dr. Spencer, 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 and staff for diagnostic purposes or dental treatment.

I understand that root canal therapy is an attempt to save a tooth, which otherwise could be lost. Although root canal therapy has a high degree of success, it is still a biological procedure and cannot be guaranteed. Occasionally, a tooth that has had root canal therapy may require retreatment, surgical intervention or extraction.

Upon completion of root canal treatment, I am to return to my dentist for the definitive restoration within 4 weeks or additional treatment may be required or result in necessary removal of the tooth.
Please Initial _____

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