



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.