Health Questionnaire

Referred by: _____ Date _____

Name _____ Address _____
Last First Middle

_____ ( ) _____ ( ) _____
City State Zip Code Home Phone Business/Cell Phone

Date of Birth _____ Sex _____ Height _____ Weight _____ Place of Employment _____

Soc Security No. _____ Single ___ Married ___

Name of Spouse _____ Phone _____ **Employment of Spouse** _____

Emergency Contact _____ **Phone** _____

(Parent of Minor)

If you are completing this form for a minor, what is your name: _____ Relationship: _____

Address (if different from Minor) _____ Home Phone _____

Signature of Responsible Party: _____ Date of Birth _____

Your answers are for our records only and will be considered confidential.

Are you in good health? ---------- Yes No

Has there been any change in your general health in the past year? ---------- Yes No

Your last physical examination was on _____

Are you currently under the care of a physician? ---------- Yes No

If so, what is the condition being treated? _____

The name, address and telephone number of your physician is _____

_____

Have you been hospitalized, had a serious illness or operation within the past five years? ---------- Yes No

If so, what was the problem? _____

_____

Circle any of the following conditions which you have had or have at present:

Abnormal heart condition	Lung Disease	Hepatitis - **Type** _____
Heart murmur	Venereal Disease (Syphilis/Gonorrhea)	Liver Disease
Pacemaker	Allergies or Hives	Diabetes Disease I or II
Heart surgery	Addiction (Drug, alcohol, gaseous)	Kidney Trouble
Rheumatic Fever	Thyroid Disease	Hypoglycemia (Low Blood Sugar)
High Blood Pressure	Cancer or Tumor	Epilepsy or Seizures
Scarlet Fever	X-Ray, Radium, or Cobalt Treatment	Fainting/Dizzy Spells
Artificial Joint	Chemotherapy (Cancer, Leukemia)	Emotional Disease
Anemia or Blood Disorders	Glaucoma	Hemophilia
Stroke	Pain in Jaw Joints	Asthma

Do you have any disease, condition, or problem not listed above that you think I should know about? Yes No

If so, explain _____

_____

Have you had abnormal bleeding or any serious trouble associated with previous dental treatment such as extraordinary surgery or trauma? If yes, please explain _____

_____

EMAIL ADDRESS: _____

- OVER -

Are you taking any of the following drugs (include dosage and frequency)?

a. Antibiotics or sulfa drugs ..... Yes No
b. Anticoagulants (blood thinners) ..... Yes No
c. Medicine for high blood pressure ..... Yes No
d. Cortisone ..... Yes No
e. Tranquilizers ..... Yes No
f. Antihistamines ..... Yes No
g. Aspirin ..... Yes No
h. Insulin, tolbutamide, (Onnase) or similar drug ..... Yes No
i. Digitalis or drugs for heart trouble ..... Yes No
j. Nitroglycerin ..... Yes No
k. Oral contraceptive or other hormonal therapy ..... Yes No
l. Other (please list) _____

Are you allergic or have you reacted adversely to:

a. Codeine ..... Yes No
b. Penicillin or other antbiotics ***please list*** _____ Yes No
c. Barbiturates, sedatives, or sleeping pills ..... Yes No
d. Latex ..... Yes No
e. Aspirin ..... Yes No
f. Local anesthetics ..... Yes No
g. Other (please list) _____

Women only: Is there a possibility that you may be pregnant? _____ What month? _____ Nursing? _____

DENTAL INSURANCE: YES / NO (Please circle and provide dental insurance card)

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Tyler Endodontics all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I am also responsible for benefits verification and provider participation. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I understand that a partial payment or full payment is due at the time of treatment. I authorize the use of this signature on all insurance submissions. Signature of patient or authorized insured: _____ ← (Sign here if we are filing insurance for you)

METHOD OF PAYMENT:(CIRCLE ONE) CASH / CHECK / CREDIT CARD (ALL MAJOR CREDIT CARDS) PRE-APPROVED CARECREDIT

(Tyler Endodontics offers a 6 month no interest plan with CareCredit, if paid in full by promotional plan period) All refunds will be issued in check form, except for CareCredit. CareCredit refunds will be credited back to your CareCredit account. Payment arrangements will not be made at time of appointment.

INFORMED CONSENT

I understand that Root Canal treatment is a procedure to retain a tooth which may otherwise require extraction. Although Root Canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Occasionally a tooth which has had a Root Canal therapy may require retreatment, surgery, or even extraction. I also understand that the permanent outside restoration (crown) will be done by my regular dentist.

Although rare, the following complications may occur in endodontic therapy in the following percentages: pain and swelling 5%, damage to an existing crown or filling 1/2%, fracture of a root less than 1%, fracture of a fine instrument in root canal 1%, over-fill, underfill or perforation of a root less than 5%

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I wil I will inform the doctor without fail. I hereby give my consent to perform necessary diagnostic tests (including x-rays), evaluation and treatment. I understand that I am responsible to pay for services rendered in this office.

Signature of Endodontist

Signature of Patient Date

Signature of Parent/Guardian (if minor) Date