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
_____T obacco 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® 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. Madison, Dr. Barr 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. Madison, Dr. Barr 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 Signature (Parent/Guardian) Date