Endodontic Specialists

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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:

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☐ 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.