Welcome to Sugar Land Endodontics

Please take a few minutes to fill out this form as completely as you can. Let us know if we can be of any assistance.

Today's Date: _____

Name: _____ Phone #: _____ 2nd phone #: _____
First Name Middle Initial Last Name

Is there a different name you prefer to be called? : _____

Address: _____

City: _____ State: _____ Zip: _____ SSN: _____ -- _____ -- _____

Sex: **M** ☐ **F** ☐ Age: _____ DOB: _____ Single / Married / Widowed Other _____
(Month/Day/Year)

Employer: _____ Occupation: _____

Who is your general dentist? Dr. _____ **Your Email:** _____

In case of Emergency: _____ Phone #: _____ Relation to patient: _____

Responsible Party Information *(This section is for patients under 18years of age)*

Name: _____ DOB: _____ Relation to Patient _____

Primary contact: _____ Secondary contact: _____

Tell us about your symptoms:

1. Reason for this visit: _____
2. Prior to this appointment, has root canal treatment been started on **this** tooth?: **Yes** **No**
3. Do you know of any trauma/injury associated with this tooth or area of the mouth?: **Yes** **No**
4. Has a recent restoration (filling/crown) been placed on this tooth? **Yes** **No**
5. Which area(s) do we need to check for you? upper right upper left lower right lower left upper front lower front
6. Are you experiencing pain at this time? **Yes** **No**

If you have never experienced any pain or discomfort with this tooth, *please skip to question #11.*

7. When did you first notice your symptoms? _____
8. What makes your tooth hurt? (*circle all that apply*) cold hot sweets chewing hurts spontaneously other : _____
9. How long do you typically feel this pain? _____seconds _____minutes _____ hours _____days/constant
10. Please rate your pain level right now on a scale of 1 to 10. 1-----2-----3-----4-----5-----6-----7-----8-----9-----10
Very mild moderate severe
11. Does it hurt to press the gum tissue around this tooth? **Yes** **No**
12. Do you grind or clench your teeth at night? **Yes** **No**
13. Do you wear a night guard? **Yes** **No** Height: _____ Weight: _____

Preferred **Pharmacy**: _____ **Phone Number:** _____

THIS FORM HAS TWO SIDES – PLEASE COMPLETE BOTH

Medical History:

Physician's (PCP) Name: _____Phone #:_____

Circle ***if you have been diagnosed with or if you have been told you have any of the following:***

AIDS/HIV Positive
Anxiety
Back problems
Chemical dependency
Cough (persistent or bloody?)
Claustrophobia
Fainting/Syncope
Glaucoma
Herpes - Cold Sores
Kidney disease
Lupus
Psychiatric care
Scarlet/Rheumatic Fever
Stroke : When? _____
Surgical implant (specify below)
_____
Thyroid Problems
Tuberculosis
Ulcerative Colitis/Chrons
Hepatitis **A B C Carrier**

Allergies:
Foods _____
Materials _____
Skin Rash ***(Currently)***
Seasonal

Bone/Joints:
Arthritis
Bone disease (osteoporosis, etc)
Cortisone treatments
Fibromyalgia

Blood:
Anemia
Bruise easily
Diabetes **T1 T2 Pre**
Hemophilia
High blood pressure
Low Blood pressure

Circulatory:
Swelling of feet/ankles

Cancer:
Type: _____
Chemotherapy
Radiation

Heart:
Artificial Valves
Heart Attack: When? _____
Heart Disease
Congenital - (From birth)
Arterial
Endocarditis
Murmur / Arrhythmia
MVP/Barlow
Pacemaker

Nervous System:
Alzheimer's
Cerebral Palsy
Epilepsy
MS
Parkinson's

Respiratory:
Anaphylaxis
Asthma
Shortness of Breath

☐ **NONE LISTED**

Tobacco or Vape use: Y N

Pregnant? **Y N N/A**
Due date: _____
Nursing? **Y N N/A**

Maskaphobic: Y N
(Problem with things on your face)

Do you have to Pre-med?: Y N

MEDICATION: _____

Please list any disease/known medical condition that was ***not*** on the list above: _____

_____ ☐ **NONE**

List medications you are currently taking, including any antibiotics and pain medicine: _____

_____ ☐ **NONE**
☐ **See Attached**

Allergies: Latex/band aids Aspirin Ibuprofen Codeine Penicillin/Amoxicillin Clindamycin Local Anesthetic
Other:_____ ☐ **NO KNOWN ALLERGIES**

We offer several levels of sedation! What level of sedation do you normally use with your general dentist?

☐ Local numbing
☐ Oral Sedation**
*1-2 tabs of Valium or Halcion given 1 hour prior to treatment
☐ Nitrous Oxide/Laughing gas
☐ IV sedation**
*sleep dentistry w/ an anesthesiologist

****Please Note:** Nitrous oxide, oral sedation, and IV sedation can all be used in our office, but **all three come at an additional cost, which is not covered by insurance.** If you opt to use oral Sedation, or IV sedation for your visit, we cannot perform a root canal on the same day as your consultation.

Authorization: I have reviewed the information on this form, and as of today's date it is accurate to the best of my knowledge. I understand that the doctor will use this information in order to determine appropriate and healthful endodontic treatment. **I understand this office will file claims on my behalf to the insurance I have provided, and that I am financially responsible for all charges on my account, whether the claim is paid by insurance or not.** I authorize the use of this signature on all insurance submissions. I authorize the endodontist to release all information necessary to secure the payment of benefits. I understand that payment is due in full at time of treatment, unless prior arrangements have been approved.

Signature_____ **Date** _____

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