Root Canal ROOT Dental Trauma
CENTER

Patient Information

Name____

Last First Middle

DOB_____/______/_________ Social Security# ________-_______-__________

Sex: F ☐ M ☐ Married ☐ Divorced ☐ Single ☐ Child ☐

Address___________________________ Apt#________________ City__________________

State_____________________________ Zip Code____________ County_______________

Cell (____) _______-__________ Home Phone (______) ______-_________

Email______________________________________ Driver's License #_____________________

Employer/ School _________________________ Employer/School Phone (___) ______-_____

Who may we thank for referring? ____

Emergency Contact ____ Phone # (____) ______-_______

Responsible Party (If same as above please skip, if parent please fill out)

Name____ ________________________

Last First Relation to patient

DOB_____/______/_________ Social Security# ________-_______-__________

Address______________________________________ Apt#_______________ City_____________

State___________________________ Zip Code_________________ County__________________

Cell (______) _______-__________ Home Phone (______) ______-_________

Email______________________________________ Driver's License # _______________________

Insurance Information

Policy Holder Name _________________________________ DOB ____/_____/_______

Member Id or Social Security # _________________________ Group # ____________________

Insurance Name ___________________________________ INS phone # (____)-_______-_____

Insurance Address ______________________ City___________________ State ______________

Employer Name ________________________________ Employer Phone # (____) _____-_____

Dental History

Reason for today's Visit? _________________________ Date of last Dental Visit ___ /____ /____

Check if you have had any of the following problems:

How often do you Brush? _________ How often do you Floss? _______

- Bad Breath
- Grinding teeth
- Sensitivity to hot
- Food collection between teeth

☐ Bleeding Gums
☐ Clicking or popping Jaw
☐ Sensitivity to cold
☐ Loose teeth or broken teeth

Medical History

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Are you under a Physician's care now? (If yes explain)

____

Have you ever taken Phen-Fen or Redux? (If yes explain)____

Have you ever been hospitalized or had any major operations? If yes, explain

____

Have you ever had a serious head or neck injury? If yes, explain

____

Have you ever taken Fosamax, Boniva, Actonel or any medication containing bisphosphonates? (If yes, explain)

____

Are you allergic to any of the following?

• Aspirin	☐ Penicillin	☐ Codeine	☐ Latex
• Acrylic	☐ Metal	☐ Sulfa Drugs	☐ Local Anesthetics

If Yes Explain____

If you are taking any medications please list them: ____

____

If you have any of the following conditions check:

• Anemia	☐ Arthritis	☐ Artificial Heart Valve	☐ Asthma
• Artificial Joints	☐ Blood diseases	☐ Blood transfusion	☐ Cancer
• Chemotherapy	☐ Chest Pains	☐ Cold sores	☐ Convulsions
• Diabetes	☐ Epilepsy	☐ Emphysema	☐ Excessive Bleeding
• Fainting	☐ Frequent cough	☐ Frequent Diarrhea	☐ Frequent headach
• Glaucoma	☐ Heart Murmur	☐ Heart Problems	☐ Hepatitis A
• Hepatitis B/C	☐ Herpes	☐ High Blood Pressure	☐ HIVS
• Peacemaker	☐ High Cholesterol	☐ Hypoglycemia	☐ Hemophilia
• Kidney Disease	☐ Liver Disease	☐ Leukemia	☐ Low blood pressure
• Lung Disease	☐ Osteoporosis	☐ Thyroid Disease	☐ Respiratory Disease
• Rheumatism	☐ Renal Dialysis	☐ Radiation Treatment	☐ Mitral Valve Prolapse
• Scarlet Fever	☐ Shingles	☐ Sinus Trouble	☐ Skin Rash
• Short breath	☐ Stroke	☐ Spina Bifida	☐ Stomach Disease
• Swelling Limbs	☐ Tonsillitis	☐ Tobacco Habit	☐ Tuberculosis
• Ulcers	☐ Venereal Disease	☐ Yellow Jaundice	☐ Pregnant

Have you ever had any serious illness not listed above? (If YES explain)

____

Authorization and Release

To the best of my Knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have any health change.

_________________________________ ________ / _____ / ______

Signature of Patient, Parent or Guardian Date