APEX ENDODONTICS, LLC - **Health History Form** Date:________________

Patient Name ____ Age:______________

Physician's Name: _______________________________________ Date of last visit:___________________________

Have you had any serious illnesses or operations? Explain:____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate date: _______________

(WOMEN) Are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No On birth control meds? ☐Yes ☐No

Check (✓) if you have or have had any of the following:

	AIDS or HIV Infection		Diabetes Type: ____		High/Low Blood Pressure		Respiratory Problems
	Anemia		Epilepsy / Seizures		Joint Replacement or Implant		Rheumatic Fever
	Arthritis, Rheumatism		Fainting		Kidney Diseases		Sexually Transmitted Ds
	Artificial heart valves		Glaucoma		Leukemia		Shortness of breath
	Asthma		Headaches/Migraines		Liver Disease		Stomach Trouble/Ulcers
	Blood Disease		Heart Disease		Mitral Valve Prolapse		Stroke
	Cancer		Heart Attack		Pacemaker		Swelling of Feet/Ankles
	Chemical Dependency		Heart Murmur		Persistent Cough		Thyroid Problem
	Chemotherapy		Hemophilia		Psychiatric / Nervous Condition		Tuberculosis
	Circulatory Problems		Hepatitis/Jaundice		Radiation Therapy		Other:

Do you have any disease, condition or problem not listed above?____

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MEDICATIONS		ALLERGIES
Current Medications: ____________________________		Aspirin
____		Barbiturates (sleeping pills)
		Codeine
____		Local Anesthetic (e.g. Novocain)
____		Penicillin or any other Antibiotics
		Sulfa
____		Other:

Are you anxious/nervous about dental treatment? ☐ Yes ☐ No Are you interested in nitrous oxide sedation? ☐ Yes ☐ No

INFORMATION AND CONSENT

It is the belief of this office that you should be informed about the benefits, risks and expense involved in endodontic (root canal) therapy and that you should give your written consent prior to treatment.

Root canal treatment is an attempt to retain a tooth, which may otherwise require extraction. Although root canal treatment usually has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had a root canal may require further treatment not included in the original fee such as retreatment, surgery or even extraction.

RISKS SPECIFIC TO ENDODONTIC THERAPY: Treatment will be performed in such a manner to minimize the risks. These risks include (but are not limited to): instruments broken within root canals, missed canals, perforations (extra openings) of the crown or root of the tooth; damage to bridges, existing fillings, crowns or porcelain veneers; loss of tooth structure in gaining access to the canals and cracked teeth.

During treatment, complications may be discovered which make treatment impossible. If this occurs you will be advised, the treatment will be terminated and the fee will be adjusted (usually 50% of the complete root canal fee). These complications may include: curved roots, gum disease, splits or fractures of the tooth, or blocked canals due to; fillings, prior treatment, natural calcifications or broken instruments.

I, the undersigned, consent to receive special consultation and, should I agree to accept treatment, I consent to the performing of whatever procedure may be necessary. I acknowledge full responsibility for the payment of such services and agree to pay them in full. I also agree to pay for all collection costs for any outstanding account balance. I understand that only the root canal treatment will be done in this office. The permanent restoration (filling, inlay, crown, etc.) will be done by my regular dentist at his/her office, within 2-4 weeks.

SIGNATURE ____ DATE ____________