Lake Oconee
Endodontics

Patient Medical History

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? If yes, please explain_____	☐	☐
3. Are you taking any medication(s) including non prescription medicine? List_____	☐	☐
4. Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications containing bisphonphonates?	☐	☐
5. Do you use tobacco?	☐	☐
6. Do you use controlled substances?	☐	☐
7. Do you take blood thinners?	☐	☐

8. Are you allergic to or have you had reactions to the following?	Yes	No
Local Anesthetics (e.g. Novacain)	☐	☐
Penicillin, Tetracyclines or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (e.g. nickel, mercury, etc.)	☐	☐
Latex Rubber	☐	☐
Other (please list)_____		
9. ***Women Only:***		
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking oral contraceptives?	☐	☐

Do you or have you had any of the following?

	Yes	No		Yes	No		Yes	No
Rheumatic Fever	☐	☐	Epilepsy/Convulsions	☐	☐	Stomach Troubles/Ulcers	☐	☐
Heart Murmur	☐	☐	Leukemia	☐	☐	Chest Pains	☐	☐
Joint Replacement or Implant	☐	☐	Diabetes	☐	☐	Stroke	☐	☐
Mitral Valve Prolapse	☐	☐	Kidney Diseases	☐	☐	Tuberculosis	☐	☐
Artificial Valves (stints or conduits)	☐	☐	AIDS or HIV Infection	☐	☐	Radiation Therapy	☐	☐
History of Ineffective Endocarditis	☐	☐	Thyroid Problem	☐	☐	Liver Disease	☐	☐
Serious Congential Heart Conditions	☐	☐	Heart Disease	☐	☐	Heart Trouble	☐	☐
High Blood Pressure	☐	☐	Cardiac Pacemaker	☐	☐	Respiratory Problems	☐	☐
Heart Attack	☐	☐	Angina	☐	☐			
Swollen Ankles	☐	☐	Emphysema	☐	☐			
Fainting/Seizures	☐	☐	Cancer	☐	☐			
Asthma	☐	☐	Hepatitis/Jaundice	☐	☐			
Low Blood Pressure	☐	☐	Sexually Transmitted Disease	☐	☐			

Current Dental Concern

Area of Concern:

Top Right _____ Bottom Right _____
Top Left _____ Bottom Left _____
Top Front _____ Bottom Front _____

Type of Pain:

Mild_____ Moderate_____ Severe _____

Pain Occurs to:

Cold_____ Hot _____ Biting _____ For no Reason _____

Is There Swelling?

Yes _____ No _____

Authorization & Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of Patient (or parent/guardian if patient is a minor) *Date*