SOUTHCOAST
Endodontics
Comprehensive care for a lifetime of natural smiles.

Name (First)_____(MI)____(Last)_____Date of Birth _____

Address (street)_____(city,state,zip) _____

Phone (home)_____(work)_____(mobile) _____

Email_____ SS#_____ Gender M / F

Marital Status: S / M / W / D Spouse's Name _____

Patient Employed by_____ Address _____

Emergency Contact Information: Name_____ Relationship to patient_____

Address_____ Phone _____

Name of parent or guardian if patient is a child _____

Responsible Party Name _____ Relationship to Patient _____

Address (if different than above) _____

Name of General Dentist_____ Referred by_____

Other Specialists_____ Physician's Name _____

How did you hear of our practice?_____ Last Physical Exam Date_____/_____/_____

Dental Insurance _____ ID#_____ Group # _____

Insured_____ DOB___/___/____ Relationship: Self / Spouse / Parent (Guardian)

Second Carrier _____ ID#_____ Group # _____

Insured_____ DOB___/___/____ Relationship: Self / Spouse / Parent (Guardian)

PLEASE PROVIDE YOUR CARD(S) SO THAT WE CAN MAKE A COPY.

PLEASE NOTE: IF ANNUAL MAXIMUM IS REACHED, NO ADJUSTMENTS WILL BE MADE. PATIENT IS RESPONSIBLE FOR REMAINING BALANCE IN FULL. A $50 FEE WILL BE APPLIED FOR ANY RETURNED CHECK.

INFORMED CONSENT

I understand root canal treatment is a procedure to retain a tooth that may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Occasionally, a tooth that has had root canal therapy may require retreatment, surgery or even extraction. I also understand that only the root canal treatment is to be performed at this office. The permanent (outside) restoration (filling, onlay, crown, etc.) will be done by my regular dentist. I understand I have the right to refuse treatment and that I am responsible if I terminate treatment against doctor's advice. I give permission to Southcoast Endodontics to perform procedures, including the giving of local anesthetics or taking of radiographs that may be necessary for my dental treatment. I also acknowledge full responsibility for the payment of such services and agree to pay for them in full AT OR BEFORE COMPLETION unless other specific arrangements are made with the office. I authorize my insurance carrier to issue the dental benefits of my plan directly to this dental office. I also authorize release of any information necessary to process dental insurance.

_____ Date:_____
Signature of Patient

_____ Date:_____
Signature of Dentist

Please answer the following questions, YES OR NO, if you have or have had any of the following:

1. Have there been any changes to your general health within the past year? YES NO
2. Are you now under the care of a physician? YES NO
   If so, what is the condition being treated?_____
3. Have you had any serious illness or operation requiring hospitalization in the last 5 years? YES NO
   If so, please explain_____
4. Have you ever suffered from alcoholism or drug addiction? YES NO
5. Are you being treated for depression? YES NO
6. Do you have or have you had any of the following diseases or problems?

a. Cancer or history of cancer	YES	NO	l. Arthritis	YES	NO
b. Rheumatic fever or rheumatic heart disease	YES	NO	m. Inflammatory rheumatism	YES	NO
c. Congenital heart defects	YES	NO	n. Stomach ulcers	YES	NO
d. Pacemaker or prosthetic heart valves	YES	NO	o. Kidney trouble	YES	NO
e. Artificial joint replacements	YES	NO	p. Tuberculosis	YES	NO
f. Hives or skin rash	YES	NO	q. Blood pressure (please circle) HIGH LOW	YES	NO
g. Fainting spells or seizures	YES	NO	r. HIV, AIDS or ARC	YES	NO
h. Diabetes	YES	NO	s. Reflux, ulcerative colitis or Crohn's disease	YES	NO
i. Hepatitis, jaundice or liver disease	YES	NO	t. Asthma:	YES	NO
			Do you use an inhaler?	YES	NO
j. Heart disease	YES	NO	u. Allergies, (please circle all that apply)	YES	NO
Please explain_____			Hay Fever, Seasonal Allergies, Sinus Trouble		
k. High Cholesterol	YES	NO			

7. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma? YES NO
8. Do you have any blood disorders such as anemia? YES NO
9. Have you had surgery or X-ray treatment for a tumor, growth or other condition of your head or neck? YES NO
10. **Please list all medications and supplements (include daily dose)**

_____

_____

_____

_____

Antibiotics may alter the effectiveness of oral contraceptives. Please consult with your physician for recommendations regarding alternative methods of birth control while taking antibiotics.

11. **DO YOU REQUIRE ANTIBIOTICS PRIOR TO ANY DENTAL TREATMENT? YES NO**
12. **Are you allergic to any medications or latex? YES NO**
    If so, please specify_____
13. Have you had any serious trouble associated with any previous dental treatment? YES NO
    If so, please explain_____
14. Do you have any disease, condition or problem not listed above? YES NO
    If so, please explain_____
15. **Are you taking (or have you taken in the past) any form of bisphosphonate (example: FOSAMAX®)? YES NO**

WOMEN

16. Are you pregnant? YES NO
17. Are you nursing? YES NO