REFERRING DENTIST NAME: _____

MR.
MRS.
MS.
DR.

_____

Patient (Please Print)

Address_____ Date of Birth _____

City, State, Zip_____ Main Phone _____

E-mail _____ Alt Phone _____

In Case of Emergency, Call:_____ Phone _____

Spouse/Parent/Relative/Friend's

Employer_____ City _____

Physician's (M.D.) Name_____ City _____

Are you under a physician's (M.D.) care now? ☐ No ☐ Yes If yes, please give reason for treatment:

_____

Preferred Pharmacy _____ Height ___X___ Weight ___X___ (if under 18)

Have you had or do you presently have any of the following conditions? Check YES or NO in every case.

	YES	NO		YES	NO		YES	NO
Allergies (to medications)			High Blood Pressure			Psychiatric Disorder		
Anemia			Low Blood Pressure			Rheumatic Fever		
Asthma			HIV+/AIDS			Severe Infections		
Cancer (chemo)			Joint Replacement			Stroke		
Cancer (no chemo)			Kidney Disease			Thyroid Disease		
Diabetes			Liver Disease			Transfusions		
Drug/Alcohol Abuse			Lung Disease			Tuberculosis		
Heart Disease			Organ Transplant			Tumors		
Heart Murmur			Pneumonia					
Hepatitis (type)			Prolonged Bleeding					

Are you taking any medication at this time? ☐ No ☐ Yes If yes, please give medication name(s) below:

_____

_____

Have you ever had an unusual reaction to any of the following?
Check YES or NO in every case.

	YES	NO		YES	NO		YES	NO
Dental Local Anesthetics			Penicillin			Latex		
Aspirin Compounds			Tetracyclines			Other		
Codeine Compounds			Sulfa Drugs					
Barbiturates			Erythromycin					

WOMEN: Are you pregnant? ☐ NO ☐ YES If yes, how many months? _____months

NOTE: Antibiotics render birth control pills less effective!

PATIENT SIGNATURE_____ **DATE** _____

(Parent or Guardian, please sign if patient is a minor)

TREATMENT INFORMATION:

TOOTH NO.____________ CLAMP NO.__________

Canal	Length		Size	
SINGLE				
BUCCAL				
PALATAL				
MESIOBUCCAL				
MESIOLINGUAL				
DISTOBUCCAL				
DISTOLINGUAL				
DISTAL				

GG USED__________

POST ROOM # ____________ at ____________MM

TREATMENT INFORMATION:

TOOTH NO.____________ CLAMP NO.__________

Canal	Length		Size	
SINGLE				
BUCCAL				
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DISTOLINGUAL				
DISTAL				

GG USED__________

POST ROOM # ____________ at ____________MM

DATE	TREATMENT RECORD