MEDICAL HISTORY

Please circle any of the following which may apply to you now or in the past:

Tuberculosis	Heart Failure	Angina Pectoria	Sinus Trouble	Liver Disease
High Blood Pressure	Heart Disease or Attack	Allergies or Hives	Yellow Jaundice	Bleeding Problems
Diabetes	Artificial Heart Valve	Heart Pacemaker	Drug Addicition	Anemia
Ulcers	Rheumatic Fever	Congenital Heart Lesions	Thyroid Disease	Artificial Joint
Systemic Bacteremia	Mitral Valve Prolapse	Hepatitis A (infectious)	Pain in Jaw Joints	Fainting or Dizzy Spells
Fungal Infection	Heart Murmur	Hepatitis B (serum)	AIDS	Bruise Easily
Glaucoma	Heart Surgery	Hepatitis C	HIV Positive	Epilepsy or Seizures

Do you need to pre medicate prior to any dental treatment? YES ☐ NO ☐

Any other diseases or problems? _____

WOMEN: Are you pregnant? _____ If so, what month? _____

Have you ever had an unusual reaction to an anesthetic or drug such as Penicillin, Erythromycin, Novacaine, Codeine, Aspirin, ETC.? YES ☐ NO ☐ If yes, please explain _____

_____

_____

Medications taking at present _____

_____

Have you taken Aspirin or Ibuprofen in the last 72 hours? YES ☐ NO ☐ Aspirin ☐ Ibuprofen ☐

Approximately how many? _____

The purpose of endodontic treatment or root canal treatment is an attempt to save a tooth rather than removing it. Although treatment has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had root canal treatment may require retreatment, surgery or even extraction.

Treatment is usually a non-surgical procedure, but in some cases, a surgical approach is necessary. Before any treatment has begun the reason(s) will be fully explained, including alternative modes of therapy, and any possible complications involved. Occasionally, premedication may be indicated. This will be discussed in advance.

THE FEE WILL NOT INCLUDE A PERMANENT FILLING OR CROWN ON THE TOOTH. YOU MUST RETURN TO YOUR GENERAL DENTIST TO HAVE THAT TREATMENT COMPLETED.

I understand I am financially responsible for all services and fees incurred.
An interest rate of 1.5% will be added to all balances over 60 days.

DATE _____ SIGNATURE _____
(patient, or parent/guardian of minor patient)

I hereby authorize my insurance benefits to be paid directly to North Suburban Endodontics and I also authorize the Doctor to release any information required to process insurance claims.

DATE _____ SIGNATURE _____
(patient, or parent/guardian of minor patient)