PROFESSIONAL ENDODONTICS OF ILLINOIS

THE FOLLOWING CONFIDENTAL INFORMATION IS FOR OUR RECORDS ONLY

Name …… Spouse's Name……
Date of Birth…… Spouse's Date of Birth……
Social Security No…… Social Security No……
If a Minor, Parent's Name ……Marital Status……
Address……Phone (…..)……Ext……
City……State……Zip……
Physician……Phone (……)……
Referring Dentist……Phone (…..)……
Dental Insurance Co……Phone (…..)……
Who is responsible for this account ……
Who may we contact in case of an emergency? Name……
Address……Phone (…..)……

MEDICAL HISTORY

1. Are you in good health?…… **YES/NO**
2. **a.** Have you been in a hospital or had a serious illness or accident within the past 2 years?…… **YES/NO**
b. if so, what was a problem? ……
3. Are you under the care of a physician?…… **YES/NO**
4. Are you allergic to:
a. Local Anesthetics?…… **YES/NO**
b. Penicillin or another antibiotic?…… **YES/NO**
c. Codeine or other narcotics?…… **YES/NO**
d. Latex?…… **YES/NO**
e. Other…… **YES/NO**
YES/NO
5. Do you usually pre-medicate yourself for any dental treatments?…… **YES/NO**
6. **WOMEN** Are you pregnant?…… **YES/NO**
7. **WOMEN** Are you nursing?…… **YES/NO**

PLEASE COMPLETE THE FOLLOWING IN FULL **(CIRCLE YES OR NO)**

• Angina (chest pain) **YES/NO**	• Abnormal **YES/NO** (Blood Pressure)	• Jaundice **YES/NO**	• Immune Suppressive Disorders **YES/NO**
• Heart Trouble **YES/NO**	• Rheumatic Fever , **YES/NO**	• Hepatitis **YES/NO**	• Cancer **YES/NO**
• Heart Murmur **YES/NO**	• Anemia **YES/NO**	• Tuberculosis **YES/NO**	• Epilepsy **YES/NO**
• Pace Maker **YES/NO**	• Kidney Trouble **YES/NO**	• Sinus Trouble **YES/NO**	• Stomach Ulcers **YES/NO**
• Damaged or Artificial (heart valves) **YES/NO**	• Asthma **YES/NO**	• TMJ **YES/NO**	• Psychiatric Problems **YES/NO**
• Heart Attack **YES/NO**	• Diabetes **YES/NO**	• Aids **YES/NO**	• Arthritis **YES/NO**
		• HIV **YES/NO**	

If you are presently using medication, please list……
……
I understand that only the root canal therapy is to be done at this office. The permanent (outside) restoration (filling, inlay, crown, etc.) will be done by my regular dentist. Proper post-treatments restoration is a necessity.

Signature……Date…… ,
Patient or Patient of Minor