

CT SCAN ____
X-RAY ____
TOOTH # ____
RCT RETX EXT

Personal History

(Information will be held in strict confidence)

“Please Print”

Date: _____

Patient Name: _____

Parent's Name (if minor patient): _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: _____ Date of Birth ____/____/____ Social Security #: ____-____-____

Drivers License #: _____

Day Phone: _____ Evening Phone: _____

Email Address: _____

Employer: _____ Occupation: _____

Emergency Contact (Name and Phone Number):

Referred By: _____

(Whom may we thank for referring you?)

Financially Responsible Individual

(If different than patient or if there is **Dental Insurance**)

Do you have dental insurance? Yes ____ No ____

Dental Insurance: _____ ID: _____ Group #: _____

Address: _____

Responsible individual: _____ Relation to Patient: _____

Address: _____

City: _____

Sex: _____ Date of Birth: ____/____/____ Social Security # ____/____/____

How will you be paying for today's services?

Credit Card ____ Check ____ Cash ____

Signature: _____

Medical History

Date of Last Dental Visit: _____

Name of Treating Dentist/Other Doctor: _____

Address: _____

Preferred Pharmacy: _____ **Pharmacy Phone #:** _____

DO YOU HAVE OR HAVE YOU EVER HAD (If unknown, please indicate unknown):

YES	NO		YES	NO	
___	___	Anemia	___	___	Kidney Disease
___	___	Asthma	___	___	Hepatitis A/B/C
___	___	Diabetes	___	___	Rheumatic Fever
___	___	Cancer	___	___	Thyroid Condition
___	___	High Blood Pressure	___	___	Tuberculosis
___	___	Radiation Treatment	___	___	Stroke or Heart Attack
___	___	Abnormal Heart Condition	Allergies to any of the Following:		
___	___	Do You Have a Pacemaker?	___	___	Penicillin
___	___	Abnormal Bleeding From a Cut?	___	___	Local Anesthetic
___	___	Surgery	___	___	Aspirin
___	___	Joint Surgery or Replacement	___	___	Latex
___	___	Are You Pregnant?	___	___	Codeine
___	___	Immune System Disorder/Disease	(Other Allergy Specify): _____		
___	___	Mental/Neural Condition	___	___	Any Contagious Diseases
___	___	Epilepsy/Fainting	___	___	Venereal Disease
___	___	Glaucoma/Vision	___	___	AIDS/HIV Positive
___	___	Alcohol/Other Addiction	___	___	Other (Please specify) _____

Please list all medications you (the patient) are currently taking and for what: _____

The following is to be completed by Patient or, if minor, patient's legal guardian:

I have read and understand this form and have answered all the questions to the best of my ability.

Patient's Signature: _____ **Date:** _____

Legal Guardian's Signature: _____ **Date:** _____

(If patient is a minor/child) **Relationship to Child/Minor:** _____

Doctor's Signature: _____ **Date:** _____

Witness's/ Dental Assistant's Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse To Sign This Agreement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

(Please Print Name)

Signature: _____ **Date:** _____

For Office Use Only

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign

___ Communications barriers prohibited obtaining the acknowledgment

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please Specify) _____

EDUCATION FOR PATIENTS REGARDING OPIOID USE

It is not uncommon for a tooth to be uncomfortable or even exhibit a dull ache immediately after receiving root canal therapy. The amount of discomfort after is often related to the amount of discomfort prior to treatment and will usually subside within one week if not sooner, but can last up to two weeks in some cases. We recommend acetaminophen, ibuprofen, and naproxen to be the best choice for pain relief after root canal treatment. In the rare event your pain is not relieved using over the counter medications, the doctor may prescribe an opioid. The decision to take prescription opioids is your choice. Prescription opioids can be used to help more severe pain when recovering from root canal therapy or surgery. Medications are an important part of your treatment when necessary and you should work closely with our prescribing doctor to understand the risks and benefits of taking any medications, including opioids. Knowing your options for pain management is important. Opioid use can have a number of side effects such as:

- Nausea, vomiting or dry mouth
- Sleepiness and dizziness
- Confusion
- Depression
- Itching and sweating
- Constipation
- Addiction
- Opioid overdose can cause slowed breathing and even be fatal

If you discuss all your pain management options and risks with your doctor and you decide taking prescribed opioids is the best choice for your pain management:

- Understand all the risks and side effects of opioids use (Additional resources can be found on the CDC and FDA websites www.fda.gov and www.cdc.gov).
- Always take the prescribed opioid as directed by your prescribing doctor and never take more than your doctor ordered, or more frequently than your prescribing doctor ordered.
- Never use another person's prescription opioids or share, sell or trade your own prescription opioids.
- Do not take other medications or prescribed opioids from other doctors without informing them of any and all medications you are taking and any potential drug interactions.
- Report any and all medications and health issues to your prescribing doctors before taking opioids and bring the pill bottle with to any hospital or doctor's visits.
- Report any addiction problem to your doctor.
- The prescribing doctor will prescribe an appropriate number of pills to manage your pain. If your medicine is lost or stolen or used up sooner than prescribed, your medication may not be replaced. If a refill is required, contact your doctor's office during normal business hours. No refills will be provided on nights, holidays or weekends.
- Properly dispose of any unused prescription opioids.

Your doctor will consult the state Prescription Drug Monitoring Program (PDMP) before prescribing you opioids.

My signature below acknowledged I have read and understand the information provided to me and my questions have been answered.

Patient's (or Legal Guardian's) Signature

Date