MISSION ENDODONTICS

PATIENT'S HISTORY AND INFORMATION

CERTIFIED SPECIALISTS IN ENDODONTICS

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Patient MR. MRS. MISS. ______________________ Last ______ First ______ Middle ______ Date of Birth ___ / ___ / ___ (D / M / YR) A.H.C. # __________

Home Address __________________________ Home Phone __________

City __________________________ Postal Code __________

Patient Employed by __________________________ Bus. Phone __________

Name of Spouse __________________________

Spouse Employed by __________________________ Bus. Phone __________

If Patient is a minor who is legally responsible __________________________

Patient's Dentist __________________ Patient Referred by __________________

Patient's Physician __________________ Address __________________

Are you in good health? __________________ Are you presently being treated by a physician? __________

Are you taking any medications now? __________ If yes, please list __________________

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma or Hay Fever
- ❑ Blood Disease
- ❑ Bone Disease
- ❑ Cancer - Type:
- ❑ Diabetes
- ❑ Epiepsy
- ❑ Excessive Bleeding
- ❑ Fainting Spells
- ❑ Glaucoma
- ❑ Heart Ailments
- ❑ Heart Murmur
- ❑ Hepatitis A, B, or C
- ❑ High Blood Pressure
- ❑ HIV/AIDS
- ❑ Immune Disorder
- ❑ Joint Replacement
- ❑ Pacemaker
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Nervous Disorders
- ❑ Osteoporosis
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever or Rheumatic Heart Disease
- ❑ Seizures
- ❑ Sinus Trouble
- ❑ Stroke
- ❑ Surgery - When:
- ❑ Tumors or Growths
- ❑ Other:

Women: Are you pregnant? __________________________
Please inform our office if you become pregent prior to or during the course of treatment.

FINANCIAL RESPONSIBILITY:

Do you have dental coverage? ❑ Yes ❑ No

I assume full responsibility for the payment of services rendered in the office, and agree to pay, in full, at or before completion of treatment, unless other arrangements are agreed upon, in advance. To avoid misunderstanding regarding dental insurance, we wish our patients to know that ALL PROFESSIONAL SERVICES ARE CHARGED DIRECTLY TO THE PATIENT and that PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES.

Date: __________ Signature: __________________________ Reviewed by: __________

CONSENT FOR TREATMENT:

I the undersigned, being the patient, parent or guardian of the above minor patient, consent to undergo whatever endodontic treatment produres are deemed necessary or advisable, in the opinion of the doctor.
I understand that root canal therapy is an attempt to retain a tooth that may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment surgery, or even extraction. I further understand that the FINAL RESTORATION of the tooth (with a filling, inlay, crown, etc.) will be done by my regular dentist AT AN ADDITIONAL FEE.

Date: __________ Signature: __________________________ Reviewed by: __________

PRIVACY POLICY:

It is our policy to keep all information you have provided to us confidential. Information you have provided us is used for diagnostic and billing/ insurance purposes only. We will share and provide information on a need to know basis to insurance companies, your dentist or heath care providers as part of the care we provide you. Please sign this to acknowledge and accept this privacy policy.

Date: __________ Signature: __________________________

	RIGHT								LEFT							
TOOTH #	**18**	**17**	**16**	**15**	**14**	**13**	**12**	**11**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**
Perc.																
Cold																
Heat																
Perio.																
Palp.																
Bite																
TOOTH #	**48**	**47**	**46**	**45**	**44**	**43**	**42**	**41**	**31**	**32**	**33**	**34**	**35**	**36**	**37**	**38**
Perc.																
Cold																
Heat																
Perio.																
Palp.																
Bite																

PRESENT SYMPTOMS:

- ❑ None
- ❑ Heat
- ❑ Cold
- ❑ Sweet
- ❑ Relieved by Cold
- ❑ Apical Palpation
- ❑ Pressure
- ❑ Unstimulated

- ❑ Acute
- ❑ Moderate
- ❑ Mild
- ❑ Constant
- ❑ Intermittent
- ❑ Interfers with Sleep
- ❑ Interfers with Eating
- ❑ Needs Pain Medication

ETIOLOGY:

- ❑ Deep Caries
- ❑ Deep Restoration
- ❑ Crown
- ❑ Perio/Endo
- ❑ Trauma
- ❑ Occulsion
- ❑ Prior Surgery
- ❑ Incomplete RCT
- ❑ Failing Root Canal
- ❑ Pulp Exposure
- ❑ Resorption/Fraction

RADIOGRAPHIC:

- ❑ Normal Structure
- ❑ Apical Rarefaction
- ❑ Lateral Rarefaction
- ❑ Furca Rarefaction
- ❑ Broken Instrument
- ❑ Silver Points
- ❑ Paste Fill
- ❑ Root Fracture
- ❑ Perforation
- ❑ Root Resorption
- ❑ Open Apex
- ❑ Condensing Osteitis
- ❑ Calcification of Pulp
- ❑ Resorption

CLINICAL EXAM (Crown):

- ❑ Intact
- ❑ Caries
- ❑ Fracture
- ❑ Discolored
- ❑ Opened
- ❑ Restored
- ❑ Mobility
- ❑ Pocket Depth
- ❑ Attached Gingiva
- ❑ Not Restorable
- ❑ Crown Lengthening Req.

MUCOSA:

- ❑ Normal
- ❑ Fistula
- ❑ Gum Boil
- ❑ Fluctuant
- ❑ Cellulitis
- ❑ Extra Oral
- ❑ Swelling
- ❑ Gingiva Recession
- ❑ Perio Alert

TREATMENT:

- ❑ No Treatment
- ❑ Extraction
- ❑ Retreatment
- ❑ RCT
- ❑ Pulp Therapy

CROWN PRESENT:

- ❑ (Patient warned it may chip, break or become loose)

DIAGNOSIS: