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Diplomate American Board of Endodontics

Richmond Endodontic Associates

Certified Specialists in Endodontics

Richmond Health Sciences Centre #810-6091 Gilbert Rd, Richmond, BC, V7C 5L9 **(604) 270-8754** info@endobc.com

(the following confidential information is for our records only)

Name: ____ Date of Birth: _____/_____/_____ (D M Y)
Last name First name Middle Initial

Home Address: ____
Street City Postal Code

Home Phone ____________________ Cell _____________________ Business Phone ____________________

Email ____________________________ Care card number _________________________

Name of spouse, parent, or nearest relative: ____________________________________ Phone _______________

If patient is a **minor**, who is legally responsible: __________________________________ Phone _______________

Referring Dentist: __________________________ Family Physician: _________________________

Insurance Information (if applicable):

Primary insurance company: ______________________
Group/policy #: ______________________
ID/Cert #: ______________________
Employer: ______________________
If primary coverage through spouse/partner, then please fill in:
Their name: ___________________________________
Date of birth: D______/M______/Y______

Secondary insurance company: ___________________
Group/policy #: ______________________
ID/Cert #: ______________________
Employer: ______________________
Spouse/partner name: ______________________
Date of birth: D______/M______/Y______

Dual Insurance Coverage for Children – requires both parent's birthdates:

Mother's date of birth: D______/M______/Y______ Father's date of birth: D______/M______/Y______

I authorize the release of any information relating to dental claims.

I understand that I am responsible for all the costs of dental treatment.

- We will submit the primary insurance claim and prepare any secondary claim forms on your behalf.

Permission for Root Canal Treatment and Local Anaesthetic:

Upon being informed of all treatment options, I the undersigned, being the patient or if minor, the parent or guardian, consent to the performing of whatever procedure may be determined necessary by the Doctor. I authorize and request the administration of such drugs and/or anaesthetics as may be deemed advisable by the Doctor. I also understand that upon completion of root canal therapy in this office, I will be referred to my dentist for a permanent restoration, such as, an amalgam restoration, onlay, or crown.

Patient/Parent/Guardian signature: ____ Date: D______/M______/Y______

Reviewed by: ____

Medical History: Please answer the following questions. Your answers are for our records only, and considered confidential. Please note that during your initial visit, you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Have you had any serious illness, operation, or been hospitalized in the past 5 years? If yes, what was the illness/reason?

____

Are you currently taking any medication? If yes, what are you taking? ___________________________

Does your medical history include any of the following?:

_______ 1. Rheumatic or congenital (inborn) heart disease

_______ 2. Heart murmur, damage, or artificial heart valves. If yes, do you require pre-medicate?

_______ 3. Cardiovascular disease (heart trouble, stroke)

_______ 4. High or low blood pressure. If yes, do you take medication?

_______ 5. Do you have a cardiac pacemaker?

_______ 6. Asthma, emphysema, or tuberculosis

_______ 7. Fainting, seizures, epilepsy, or neurological disorders

_______ 8. Diabetes

_______ 9. Hepatitis, jaundice, or other liver disease

_______ 10. Sexually transmitted disease

_______ 11. AIDS or HIV infection

_______ 12. Thyroid problems

_______ 13. Stomach ulcer

_______ 14. Kidney trouble

_______ 15. Mental health conditions

_______ 16. Cancer or treatment for tumor or growth?

_______ 17. Radiation therapy for cancer? Area of body treated:_________________ Date:______________

_______ 18. Problems of the immune system?

_______ 19. Blood disorders, such as anemia?

_______ 20. Abnormal bleeding?

_______ 21. Have had joint replacement surgery (knee, hip, etc.?) If yes, do you require pre-medicate?

_______ 22. Do you have any other illness or conditions not mentioned above?

Are you allergic or had any reaction to:

_______ 23. Penicillin

_______ 24. Sulfa drugs

_______ 25. Aspirin, acetaminophen (Tylenol), or Ibuprofen (Advil, Motrin)

_______ 26. Codeine or other narcotics

_______ 27. Barbiturates, sedatives, or sleeping pills

_______ 28. Local anesthetics (novocaine)

_______ 29. Any other drugs or medications

_______ 30. Latex

For women patients:

Are you pregnant? Yes_____ No_____ Are you nursing? Yes_____ No_____

In regards to your own health and our staff's health, please sign below to certify that you have answered each question to the best of your knowledge:

Patient/Parent/Guardian signature: _________________________________ Date: D_______/M_______/Y_______