Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐

First Name: _____

Last Name: _____

Birth Date: _____

Social Security #: _____

Home Address: _____

Home Phone: _____

Business Phone: _____

Cell Phone: _____

Referred By: _____

Employer: _____

Occupation: _____

Business Address: _____

Insured Person/Subscriber

Name: _____

Birth Date: _____

Social Security #: _____

Employer: _____

Spouse Name: _____

Birth Date: _____

Social Security #: _____

Employer: _____

Do you have or have you had any of the following?

Mitral Valve Prolapse (MVP)	YES ☐	NO ☐	Glaucoma	YES ☐	NO ☐
Heart Murmur	YES ☐	NO ☐	Venereal Disease	YES ☐	NO ☐
Rheumatic Fever	YES ☐	NO ☐	Kidney Disease	YES ☐	NO ☐
Angina	YES ☐	NO ☐	Ulcers	YES ☐	NO ☐
Arteriosclerosis	YES ☐	NO ☐	Cancer	YES ☐	NO ☐
High Blood Pressure	YES ☐	NO ☐	Radiation Therapy	YES ☐	NO ☐
Low Blood Pressure	YES ☐	NO ☐	Chemotherapy	YES ☐	NO ☐
Anemia	YES ☐	NO ☐	AIDS	YES ☐	NO ☐
Bleeding Problems	YES ☐	NO ☐	Psychological Diagnoses	YES ☐	NO ☐
Liver Disease	YES ☐	NO ☐	Neurological Disorders	YES ☐	NO ☐
Thyroid Disease	YES ☐	NO ☐	Trauma	YES ☐	NO ☐
Asthma	YES ☐	NO ☐	Substance Abuse	YES ☐	NO ☐
Lung Disease	YES ☐	NO ☐	Stroke	YES ☐	NO ☐
T.B.	YES ☐	NO ☐	Seizures	YES ☐	NO ☐
HIV	YES ☐	NO ☐	Surgeries	YES ☐	NO ☐
Hepatitis	YES ☐	NO ☐	Heart Problems	YES ☐	NO ☐
Diabetes	YES ☐	NO ☐	Cardiovascular Disease	YES ☐	NO ☐

1. Do you smoke? YES ☐ NO ☐

2. Are you in good health? YES ☐ NO ☐

3. Are you presently under the care of a physician? YES ☐ NO ☐

If so, what for: _____

4. Are you presently taking any drug or medications? YES ☐ NO ☐

What Medication	For What Condition

5. Have you had heart/cardiac surgery or vascular surgery? YES ☐ NO ☐

6. Do you have damaged or artificial heart valves? YES ☐ NO ☐

7. Artificial Joint or Prosthetic Device? YES ☐ NO ☐ If so, when was it placed _____

8. Do you have a cardiac pacemaker/Shunts? YES ☐ NO ☐

9. Do you experience chest pain upon exertion? YES ☐ NO ☐

10. Do you routinely take aspirin on a daily basis? YES ☐ NO ☐

Pregnant? YES ☐ NO ☐ Nursing? YES ☐ NO ☐ Birth Control Pills? YES ☐ NO ☐

Missed period or possibility of pregnancy? YES ☐ NO ☐

Please circle any of the following drugs to which you may be allergic:

Penicillin ☐ Ibuprofen (Motrin, Advil) ☐ Codeine Novocaine/Local Anesthetic ☐ Erythromycin Aspirin Latex Bleach ☐

Other Antibiotic ☐ Local Anesthetic ☐ Adrenaline ☐ Other Allergies? _____

Do you have any diseases, syndromes, symptoms or other medical problems not mentioned above? YES ☐ NO ☐

If so please explain: _____

Name and Address of Physician: _____

Signature: _____ Date: _____

Consent to Endodontic Treatment

The Florida Medical Consent Law requires doctors to advise patients of the general nature of treatment or procedures, the medically acceptable alternative procedures or treatments, and the substantial risks inherent in the proposed treatment or procedures. In signing this consent form, you are agreeing that you have been advised of these matters to your satisfaction and understand that one alternative is not to have any treatment at all with full understanding of the risks and hazards of declining treatment.

This is my consent to the endodontic procedures indicated and any other procedures deemed necessary or advisable as a corollary to the planned endodontic therapy performed by the endodontists Dr. Lauren H. or Dr. Glen B. Mitchell, associate Doctors, and any assistants with whom they work. I agree to the use of local anesthesia, depending upon the judgement of the endodontist. I understand the endodontist will consult with me prior to administering any sedation, and/or nitrous oxide analgesia. Complications of root canal treatment and anesthesia may include swelling, pain, trismus (restricted jaw opening), infection, bleeding, bruising, sinus involvement, allergic reactions, delayed healing, treatment failure and numbness or tingling sensations of the lip, gum, cheek or tongue, which is transient but on infrequent occasions may be permanent. I understand that it is my responsibility to report any symptoms to the endodontist immediately.

I understand that root canal therapy is a procedure to retain a tooth which may otherwise require extraction and that as a specialty practice, the office performs only endodontic therapy and associated surgery. Although root canal therapy has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery, or even extraction. Following treatment, the tooth may be brittle and subject to fracture. A restoration (filling, crown and/or post and core) will be necessary to restore the tooth to function within one month; this will be performed by another dentist for an additional expense. During treatment there is the possibility of instrument separation within the root canals, perforations (extra openings), damage to bridges, existing fillings, crowns or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when a tooth may not be amenable to endodontic treatment at all. Other treatment choices include no treatment, waiting for more definitive symptoms to develop, or tooth extraction. Risks involved in those choices might include but are not limited to pain, infection, swelling, loss of teeth, and infection to other areas.

At times, medication will be prescribed by the endodontist. I understand that medications for discomfort and sedation may cause drowsiness which can be increased by the use of alcohol or other drugs. I am advised against the use of alcohol or operating any vehicle or hazardous devices while taking such medications. I further understand that certain medications may cause hives and intestinal problems and if any of these reactions occur, I am to call the endodontist immediately. I understand that it is my responsibility to report any changes in my medical history to the endodontist.

Patient Signature: _____ Date: _____

Doctor Witness: _____