Dr. Brian Jafine
Partners in Endodontics

Your medical and dental health history are essential for the determination and course of your treatment in our office. It is important that you complete this questionnaire accurately as it will become part of your office record. Be assured that it will be held in the strictest of confidence.

Welcome To Our Office

Today's Date _____ Office Use/Patient's ID_____

Please print clearly

Have you been a previous patient here before? Yes ☐ ☐ No ☐ ☐

Dr. ☐ ☐ Mrs. ☐ ☐ Mr. ☐ ☐ Ms. ☐ ☐

Last Name _____ First Name _____

Date of Birth Month _____ Day _____ Year _____

Home Address _____ Apartment # _____

City _____ Postal Code_____

Home Number ( ) _____ Business Number ( ) _____

Cell Number ( ) _____

Occupation: _____ Employer: _____

Do you have dental insurance? Yes ☐ ☐ No ☐ ☐

Name of Spouse/Parent _____ Contact Number ( ) _____

Referring Dentist _____ Other Dentists you see _____

Family Physician _____ Tel. Number ( ) _____

Whom may we thank for referring you to us? _____

Your current physical health is? ☐ *good* ☐ *fair* ☐ *poor*

Are you taking any medications? ☐ *yes* ☐ *no*

If yes, please list: _____

Are you allergic to any of the following?

Aspirin ☐ ☐ yes ☐ ☐ no	Local Anesthesia ☐ yes ☐ no	Penicillin ☐ yes ☐ no
Codeine ☐ yes ☐ ☐ no	Latex ☐ yes ☐ no	Other Antibiotics ☐ yes ☐ no

Please list any other drugs or materials that you are allergic to: _____

Medical History

Have you ever had any of the following diseases or medical problems?

AIDS	☐Yes ☐No	Drug Abuse	☐Yes ☐No	Knee Replacement	☐Yes ☐No
Alcohol Abuse	☐Yes ☐No	Emphysema	☐Yes ☐No	Joint Replacement	☐Yes ☐No
Anemia	☐Yes ☐No	Epilepsy	☐Yes ☐No	Liver Disease	☐Yes ☐No
Arthritis	☐Yes ☐No	Fainting	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No
Asthma	☐Yes ☐No	Heart Attack	☐Yes ☐No	Pacemaker	☐Yes ☐No
Bleeding Problems	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Radiation Therapy	☐Yes ☐No
Blood Transfusion	☐Yes ☐No	Heart Surgery	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Breathing Problems	☐Yes ☐No	Valve Replacement	☐Yes ☐No	Seizures	☐Yes ☐No
Cancer/Chemotherapy	☐Yes ☐No	Hemophilia	☐Yes ☐No	Sinus Problems	☐Yes ☐No
Colitis/Crohn's	☐Yes ☐No	Hepatitis A/B/C	☐Yes ☐No	Steroid Therapy	☐Yes ☐No
Congenital Heart Defect	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Stroke	☐Yes ☐No
Defibrillator	☐Yes ☐No	Hip Replacement	☐Yes ☐No	SBE	☐Yes ☐No
Diabetes	☐Yes ☐No	HIV	☐Yes ☐No	Thyroid Treatment	☐Yes ☐No
Dizzy Spells	☐Yes ☐No	Kidney Problem	☐Yes ☐No	Ulcers	☐Yes ☐No

Is there any other medical condition you have that is not listed above? _____

Have you had any recent hospitalizations? _____

Have you ever taken medication for osteoporosis? ☐ yes ☐☐ no (Fosomax, Zometa, Boniva, Actonel)

Are you currently taking aspirin? ☐ ☐ yes ☐ no

Are you taking herbal supplements? ☐☐ yes ☐ no

Do you use Cannabis? ☐ yes ☐ no

Are you pregnant? ☐ yes ☐ no week # _____

Are you taking birth control pills? ☐ yes ☐ no

Dental History

Chief Complaint (reason for presentation)

_____

Are you presently in **pain?** ☐☐ yes ☐☐ no

Are any of your teeth **sensitive** to the following?

☐ hot ☐ ☐ cold ☐☐ biting pressure ☐☐ sweets ☐☐ other_____

I would like to discuss options of sedation for my dental treatment ☐☐ yes ☐ ☐ no

I hereby state that the above medical history is, to the best of my knowledge, accurate and complete. If I ever have any change in my health, or if my medications change, I will inform the doctor at the next appointment without fail, if deemed advisable. I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs or other diagnostic measures appropriate for a thorough evaluation.

Financial Policy: The major objective of our office is to provide you with the highest quality dental care. Our service is based on a friendly, mutual, but businesslike understanding between doctor and patient. We feel that misunderstandings can be minimized if you understand our office's financial policies. Although our office does not accept payment from the insurance company, our staff would be more than happy to submit your claims through our electronic billing system to ensure prompt re-reimbursement from your insurance company. Payments options are Visa, MasterCard, Interact, and cash. We do not accept personal cheques.

If you have any questions regarding insurance, billing or our financial policy feel free to discuss this with our receptionist.

Our fee does not include the cost of a permanent restoration – this is to be done by your own dentist after your root canal treatment has been completed.

Broken appointments and surgical intervention may constitute an additional fee. All fees are payable upon completion of treatment.

_____ _____

Patient's Signature **Date**

_____ _____

Dentist's Signature **Date**