

PATIENT HISTORY AND INFORMATION

Patient: _____ Date of Birth: ____ / ____ / ____
(Last) (First) (Middle Initial) (Day) (Month) (Year)

In case of an emergency, who do we call? _____ Phone # _____

If Patient is a minor, who is legally responsible? _____

Address: _____ City: _____

Postal Code: _____ Tel: (Res.) _____ (Bus.) _____

Cell Phone _____ Email: _____

Family Dentist: _____ Employer: _____

Physician: _____ Physician's Phone#: _____

Referred by (if other than dentist): _____

INSURANCE INFORMATION

Primary Insurance Policy or I.D. or
Dental Insurance Co. _____ Group # _____ Cert. # _____

Secondary Insurance Policy or I.D. or
Dental Insurance Co. _____ Group # _____ Cert. # _____

Policy Holder's name _____

MEDICAL HISTORY

1. Has there been any change in your general health within the past year? No Yes

If yes, please specify _____

2. Are you under the care of a physician for a current problem? No Yes

If yes, describe nature of treatment _____

3. Are you taking any prescription medicines or non-prescription drugs
(e.g. aspirin, herbal medications, etc.) of any kind? No Yes

If yes, please specify _____

4. Are you taking bisphosphonates now or have you ever taken them in the past
(e.g. Fosamax, Zometa)? No Yes

If yes, please specify _____

5. Have you had abnormal bruising or bleeding with previous extractions, surgery, or trauma? No Yes

6. Have you had any ALLERGIC or ADVERSE REACTIONS to anesthetics,
latex, antibiotics, or other medications? No Yes

If yes, please specify _____

7. Do you smoke tobacco? _____ No Yes



8. Do you have, or have you had, any of the following (if yes, please check):

- | | | |
|--|--|---|
| <input type="checkbox"/> Congenital Heart lesions | <input type="checkbox"/> Jaw joint problems | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Heart Murmur or Prolapsed Valve | <input type="checkbox"/> Asthma or Hay fever | <input type="checkbox"/> Radiation treatment |
| <input type="checkbox"/> Rheumatic fever or Rheumatic heart disease | <input type="checkbox"/> Blood disorders (e.g. anemia) | <input type="checkbox"/> Reactions to dental 'freezing' |
| <input type="checkbox"/> Prosthetic Heart valve | <input type="checkbox"/> Colitis | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Cardiovascular disease: heart attack, stroke, by-pass | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy, seizures, fainting | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Jaundice, Liver disease | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Nervous disorders | <input type="checkbox"/> Respiratory disease |
| <input type="checkbox"/> Hepatitis A, B, or C | | |

9. Do you have any disease, condition or problem not listed above? No Yes

10. Are you required to take antibiotics prior to dental treatment? _____ No Yes

11. Women only: Pregnant? No Yes Due Date: _____ Nursing? No Yes

Taking birth control pills? No Yes If yes, please be advised that **antibiotics may alter the effectiveness of birth control pills**. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

PAIN HISTORY

Please answer the following 9 questions:

1. Are you presently having pain? Yes No If yes, when did the pain start? _____
2. If no, when did you last have pain and when did it subside? _____
3. Are you taking any medications for your tooth? No Yes If yes, please specify _____
4. When does it hurt? Circle: cold / heat / chewing / sweet / BY ITSELF / other _____
5. Which of the following would describe your pain? Circle: mild / moderate / severe / sharp shooting / dull throb / continuous / intermittent / other _____
6. If cold hurts your tooth, when the cold is removed, does the pain linger? Yes: how long? _____ No
7. On a scale of 1 - 10 (10 being the worst) how would you rate your pain? _____
8. Are you aware of clenching and/or grinding your teeth? No Yes
9. Do you wear a night guard? No Yes

SIGNATURE _____ DATE _____

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