(The following confidential information is for our records only)

PLEASE READ AND SIGN THE BACK OF THIS FORM

Mr., Mrs., Ms.:_____ Age: ____ Date of Birth: (M/D/Y) ____/____/____

Home Address: (Street) _____ (City) _____ (Postal Code) _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Other: _____ Preferred #: Home/ Business/ Cell Phone/ Other

Email:_____

Patient Employed by: _____

Business Address: _____

Occupation: _____

Name of Ins.: _____ Care Card #: _____

Policy Plan #: _____ ID #: _____

Name of Spouse, Parent, or Nearest Relative: _____ Date of Birth: ____/____/____

Employer: _____ Occupation: _____ Phone: _____

Name of Ins.: _____ Policy Plan #: _____ ID #: _____

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

Referring Dentist: _____

Family Physician: _____

PLEASE NOTE: THE INITIAL APPOINTMENT IS FOR A CONSULTATION ONLY.

PLEASE READ: I understand that the total payment of the dental services is my responsibility and not that of the insurance company. (We will be happy to complete any insurance form so that you may be reimbursed by your insurance company for the percentage of the insurance company's fee guide). **I understand the insurance company does not always reimburse the full amount of the fee charged.**	**Initial**

Health History	Yes/ No	
1. Are you in good health?		
2. Have you been treated by a physician within the past 5 years? When? _____		
3. Have you been treated in a hospital in the last 1-2 years? Why?		
4. Are you a smoker? _____For how long? _____Previous Smoker?_____How long?_____		
5. Are you in a high risk group? (HIV, AIDS).		
6. Have you had radiation therapy recently or within the last year?		
7. Are you sensitive or allergic to Novocaine, Penicillin, Codeine or any other medication?		
8. Are you taking any medication now or recently?		
9. Have you ever had an unfavorable reaction following dental treatment?		
10. Have you ever had excessive bleeding requiring special treatment?		
11. Have you ever had any of the following illnesses? If so please circle: Stroke, Heart trouble, High blood pressure, Rheumatic fever, Asthma, Tuberculosis, Hepatitis , Jaundice, Kidney trouble, Diabetes, Epilepsy, Nervous disorders, Tumours, Pacemaker, Heart valve change?		
12. Have you had any other serious illnesses?		
13. Female patients: Are you pregnant? _____ Which month? _____ Nursing? ____		

PERMISSION FOR ROOT CANAL TREATMENT AND LOCAL ANAESTHETIC

I, the undersigned, being the patient, parent of guardian the above minor patient, 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 permanent restoration, such as an amalgam restoration, onlay, or crown.

Patient's/Parent's Signature: _____ Date: _____

Reviewed by: _____

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evergreen
ENDO GROUP

Certified Specialists in Endodontics

IN THE MATTER OR PERSONAL INFORMATION AND ELECTRONIC DOCUMENTS ACT

PATIENT AUTHORIZATION

I, _____authorize release to

Dr. _____information contained in
NAME OF DENTIST WHO REFFERED YOU HERE

Pre-authorizations and claims submitted electronically and otherwise. I also authorize the release of information pertaining to my dental coverage and benefits and treatment to the above named dentist.

The authorization shall continue in effect until the undersigned revokes the same

_____ _____

Signature of Patient *Date*

PLEASE LIST MEDICATIONS BELOW: