MEDICAL HISTORY

Information about your health will be held confidential. Your general health affects oral health and influences your care.

Patient Name: _____ Date: _____

(Please circle your answer)

Y N 1. Are you in good health?

Y N 2. Are you under the care of a physician? Reason: _____
Name & Address of Physician _____

Y N 3. Have you had surgery or been hospitalized in the last 5 years? Explain: _____

Y N 4. Are you taking any medication (*prescribed* or *non-prescribed)* or drug(s) at this time?
Names of Medications: _____
_____
_____

Y N 5. Do you take Blood Thinners or an Aspirin a day? Name of Medication: _____

Y N 6. Have you ever had an allergic or unusual reaction to any medication? (penicillin, sulfa drugs, etc.)
Names of Medications: _____

Y N 7. Have you ever had any trouble with prolonged bleeding after dental extractions, surgery, or trauma?

Y N 8. Have you ever required a blood transfusion? Reason & Date: _____

Y N 9. Have you taken cortisone or steroids in the last 2 years? What & How Long: _____

Y N 10. Are you required to take antibiotics prior to dental treatment? Reason: _____

Y N 11. Do you usually have problems getting numb for dental treatment?

Y N 12. Have you ever had any serious trouble with dental treatment? Explain: _____

13. **<u>WOMEN ONLY:</u> (please circle answer)**
Y N Are you pregnant? How Long?: _____
Y N Are you breast feeding?
Y N Are you taking birth control pills? *If yes, be advised that if you take antibiotics, an alternate method of birth control is recommended.*

14. Do you <u>NOW HAVE</u> or <u>HAVE YOU EVER HAD</u> the following? (please circle answer)

Y N Rheumatic Fever*	Y N Diabetes	Y N Arthritis
Y N Mitral Valve Prolapse*	Y N Anemia (incl. Sickle Cell)	Y N Stomach or Intestinal Ulcers
Y N Heart Murmur*	Y N Hemophilia	Y N Cancer/Tumor/Cysts
Y N Artificial Heart Valve*	Y N Blood Disorder/Leukemia	Y N Chemotherapy/Radiation Treatment
Y N Joint Prosthesis (Hip,Knee,etc)*	Y N Lung Disease/Emphysema	Y N Sexually Transmitted Disease
Y N Heart Pacemaker	Y N Asthma	Y N Herpes
Y N Angina or Chest Pains	Y N Tuberculosis	Y N AIDS or HIV Positive
Y N Heart Attack/Disease or Surgery	Y N Liver Disease or Jaundice	Y N Epilepsy or Seizures
Y N Stroke	Y N Hepatitis A, B, or C (circle)	Y N Glaucoma
Y N High Blood Pressure	Y N Kidney Disease	Y N Drug or Alcohol Problem
Y N Cardiovascular Stent	Y N Thyroid Disease	Y N Psychological Disorder
Y N Hayfever or Sinus Trouble	Y N Shingles	Y N Latex Allergy
Y N Pain in Jaw Joints (TMJ)	Y N Clench or Grind Teeth	Y N Sleep Apnea/Breathing Problems
Y N Autism	Y N ADHD (Attention Deficit)	

Do you have any disease, problem, or condition not listed above that you think I should know about? Y N (circle one)
Explain: _____

All of the above information is true and correct to the best of my knowledge. If I have any changes in my health or medications I will inform the doctor prior to treatment at the next appointment without fail.

_____
Signature of Patient, Parent or Guardian Date

(PLEASE TURN THE PAGE OVER)

MARTY J. SALTZMAN, DDS
Practice Limited to Endodontics

Patient Name (please print) _____

ENDODONTIC CONSENT

Endodontics (root canal therapy) is the specialty of dentistry devoted to the saving of teeth in which the pulp or nerves are affected. The value of a natural tooth is irreplaceable. Extraction and replacement of a tooth is usually more costly than endodontic therapy.

We would like our patients to be informed about the various procedures involved in endodontic therapy and have their consent before starting treatment. Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by conventional root canal therapy, or when needed, endodontic surgery. The following discusses possible risks that might occur from endodontic treatment, and other treatment choices.

RISKS: Included (but not limited to) are complications resulting from the use of dental instruments, medication, sedation, analgesics (pain killers), anesthetics, and injections. These include: swelling; sensitivity; bleeding; pain; infection; numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, teeth, and jaw, which is transient but on infrequent occasions may be permanent; reaction to injections; changes in occlusion (bite); jaw muscle cramps and spasms; temporomandibular (jaw) joint difficulty; loosening of teeth; referred pain to ear, head or neck; nausea; vomiting; allergic reactions; delayed healing; sinus perforations; death (extremely rare); and treatment failure.

RISKS SPECIFIC TO ENDODONTIC THERAPY: The risks include the possibility of instruments broken within the root canals; perforations (extra openings) of the crown or root of the tooth; damage to crowns, bridges, fillings, or other restorations which may require replacement; loss of tooth structure in gaining access to canals; and cracked or fractured teeth. During treatment complications may be discovered which make treatment impossible or which may require dental surgery. These complications may include: blocked canals, natural calcifications, broken instruments, curved roots, periodontal (gum) disease, splits or fractures of the teeth.

MEDICATION: Prescribed medications may cause drowsiness and lack of awareness and coordination. This may be influenced by the use of alcohol and other drugs. It is not advisable to operate any vehicle or hazardous device for at least 24 hours or until recovered from their effects.

OTHER TREATMENT CHOICES: These include no treatment, waiting for more definite development of symptoms, or tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and spread of infection to other areas.

I understand that endodontic (root canal) treatment is an attempt to save a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, as with other medical procedures, it cannot be guaranteed for any length of time. Occasionally a tooth which has had root canal therapy may require retreatment, surgery, or even extraction.

I understand that ***only*** the root canal treatment is to be performed at this office. The permanent restoration (crown, filling, etc.) is a ***necessity*** and will be completed by my general dentist soon after endodontic treatment.

CONSENT: I, the undersigned, being the patient (parent or legal guardian) consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. **I certify that I have read and fully understand the above informed consent and am free to ask any questions pertinent to my treatment.**

Signature of Patient, Parent or Guardian Date Witness

(OVER)