Welcome to Aventura Endodontic Group, LLC

Please fill this form out completely and submit it via email. The better we communicate, the better we can serve you.

About You:

Today's Date:

Full Name:

I preferred to be called: ☐ Male ☐ Female

Home Address:

City: State: Zipcode:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Seperated

Home phone #: Cell/Other #:

Work phone #: Email:

Employer:

Employer's Address:

City: State: Zipcode:

Insurance:

Dental Coverage? ☐ Yes ☐ No

Insurance Company Name:

Insurance Company Address:

City: State: Zipcode:

Insurance Company Phone #:

Group # (Plan, Local or Policy #):

Insured's Name: Relation:

Insured's Birthdate: Insured's SSN #:

Insured's Employer:

Employer's Address:

City: State: Zipcode:

Medical History:

THANK YOU for taking the time to provide us with this essential information. It will be used to select the safest and most effective means of treating you. Of course, all information on this form is completely confidential.

1) Please describe your present health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

2) Has your present health CHANGED in the last year? ☐ Yes ☐ No

3) Have you ever been HOSPITALIZED for illness or surgery?? ☐ Yes ☐ No

4) Has a doctor treated you for any condition in the last two years? ☐ Yes ☐ No

5) Are you ALLERGIC to any drugs or other substances? ☐ Yes ☐ No

If so, to what? _____

6) Have you ever experienced bleeding that was difficult to stop? ☐ Yes ☐ No

7) Are you taking any MEDICATIONS? ☐ Yes ☐ No

If so, please list them: _____

_____

PLEASE INDICATE YES OR NO **EVEN** IF YOU LONGER HAVE THEM.

Heart Trouble	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Heart Surgery	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Congenital Heart Lesions/Defects	☐ Yes	☐ No
Heart Pacemaker	☐ Yes	☐ No
Heart Valve Prosthesis	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Low Blood Pressure	☐ Yes	☐ No
Ankles Swell	☐ Yes	☐ No
Hardening of Arteries	☐ Yes	☐ No
Shortness of Breath on Mild Exertion	☐ Yes	☐ No
Chest Pains on Mild Exertion	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No
Hives/Rash	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No
Recurrent Illness	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Immune System Problems	☐ Yes	☐ No
HIV Positive, AIDS	☐ Yes	☐ No
Jaundice	☐ Yes	☐ No

Diabetes	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Persistent Cough	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Lung DIsease	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No
Frequent Colds/Sore Throats	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Fainting	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Anemia/Blood	☐ Yes	☐ No
Disease	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Tumors/Growths	☐ Yes	☐ No
Infestations	☐ Yes	☐ No
Emotional Problems or Tension	☐ Yes	☐ No
Often Thirsty	☐ Yes	☐ No
Frequent Urination	☐ Yes	☐ No
Often Fatigued or Exhausted	☐ Yes	☐ No
Frequent Headaches	☐ Yes	☐ No
Heavy Smoker	☐ Yes	☐ No
Nervous/Anxious	☐ Yes	☐ No
Depressed/Unhappy	☐ Yes	☐ No
Any Recent Unintentional Weight Changes	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No
Swollen Lymph Nodes	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Venereal Disease	☐ Yes	☐ No
Thyroid/Parathyroid Disorders	☐ Yes	☐ No
Cancer Treatment	☐ Yes	☐ No
Are You Pregnant?	☐ Yes	☐ No

Are you required to take antibiotics prior to dental treatment? ☐ Yes ☐ No

Is there any other condition or problem that you think we should know about?

Endodontic History:

To assist us in understanding and diagnosing your dental condition, please answer the following questions.

Present Dental Illness

1. What is your problem?
2. How long has this tooth been bothering you?
3. How and when accident did occur?
4. Have you taken any pain medication today?

Description of Dental Plan

1. Is the pain constant? ☐ Yes ☐ No
2. Does pain come and go? ☐ Yes ☐ No
3. Is ache a dull throb? ☐ Yes ☐ No
4. Have you taken any medication today? ☐ Yes ☐ No
5. Is ache a sharp piercing pain? ☐ Yes ☐ No
6. Does tooth awaken you at night? ☐ Yes ☐ No
7. Do you have pain in your ear? ☐ Yes ☐ No
8. Did your DDS tell you that you needed a root canal? ☐ Yes ☐ No
9. Do hot foods/fluids cause pain? ☐ Yes ☐ No
10. Do cold foods/fluids cause pain? ☐ Yes ☐ No
11. Do sweets cause pain? ☐ Yes ☐ No
12. Does cold relieve pain? ☐ Yes ☐ No
13. Are your gums sore? ☐ Yes ☐ No
14. Does tooth feel loose, too long or out of its socket? ☐ Yes ☐ No
15. Does change of altitude cause pain? ☐ Yes ☐ No

Please provide us with any other information you feel is important.

Patient's Signature (or parent/guardian if minor) :

Date/Time:

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