Welcome to Our Office!

ENDODONTIC ASSOCIATES
OF GREATER NEW YORK
515 MADISON AVENUE STE. 715 NY, NY 10022

Date:_____

Patient Information:

Please circle: Ms. Mr. Mrs. Dr. Other _____

_____ _____ _____ _____
LAST NAME FIRST NAME MI NAME PREFERENCE

Address:_____ Apt#_____ City:_____State:____Zip:_____
(IF P.O. BOX GIVE STREET ADDRESS ALSO)

Home #:_____Work #:_____ Cell #:_____ Email:_____

Social Security Number:_____-_____-_____ Date of Birth:_____ Sex: ☐ M ☐ F Spouse's Name:_____

Your Employer:_____Employer's Address:_____

General Dentist:_____ Physician:_____ Referred By: _____

Is the patient a full-time student? ☐ No ☐ Yes Name of School_____

In case of emergency contact: Name:_____Work Number:_____Home Number:_____

Pharmacy Name:_____Pharmacy Number:_____

MEDICAL HISTORY: Please check Y for "yes" or N for "no" for any of the following which may apply to you now or in the past:

Y N		Y N		Y N		Y N		Y N	
☐ ☐	Artificial Heart Valve	☐ ☐	Tuberculosis	☐ ☐	High Blood Pressure	☐ ☐	Diabetes	☐ ☐	Drug Addiction
☐ ☐	Rheumatic Fever	☐ ☐	Hepatitis A, B or C	☐ ☐	Heart Murmur	☐ ☐	Thyroid Condition	☐ ☐	Pain in Jaw Joints
☐ ☐	Mitral Valve Prolapse	☐ ☐	HIV Positive	☐ ☐	Heart Surgery	☐ ☐	Angina Pectoris	☐ ☐	Bleeding Disorders
☐ ☐	Congenital Heart Lesions	☐ ☐	Heart Disease or Attack	☐ ☐	Heart Pacemaker	☐ ☐	Artificial Joint	☐ ☐	Epilepsy or Seizures

Have you ever taken Bisphosphonates? _____ (i.e. Fosamax, Aredia, Zometa, Actonel, Boniva, Skelid, Didronel, Bonefos Ostec)

Any other diseases or problems? _____

Have you ever had an unusual reaction to latex, anesthetics, or drugs such as Penicillin, Erythromycin, Novacaine, Codeine, Aspirin, Sulfa, or any other medications?

If yes, Please explain: _____

What Medications are you taking at present?_____

Premed needed? ☐ Yes ☐ No; If yes,what medications? _____

Have you taken Aspirin or Ibuprofen in the last 72 hours? ☐ Yes ☐ No; If yes: ☐ AspirinIbuprofen;Howmany?_____

Women: Are you pregnant? ☐ Yes ☐ No; If yes,what month? _____

THE PURPOSE of endodontic treatment or root canal treatment is to save the tooth rather than remove it. Although treatment has a high degree of success, it can not be guaranteed. Occasionally, a tooth that has had a root canal treatment may require re-treatment, surgery or even extraction.

Treatment is usually a non-surgical procedure, but in some cases, a surgical approach is necessary. Before any treatment is begun the reason(s) will be explained, including alternative modes of therapy. Occasionally, pre-medication may be indicated. This will be discussed in advance.

PLEASE NOTE: The fee will not include a permanent filling or crown on the tooth. You must return to your general dentist to have that treatment completed.

I consent to necessary treatment and authorize the release of any information needed for continued treatment.

X_____ _____
SIGNATURE OF PATIENT (CUSTODIAL PARENT/GUARDIAN OF MINOR) DATE

PLEASE: How are you feeling today:

☐ Confident ☐ Happy ☐ Curious ☐ Frightened ☐ Anxious ☐ Pained

Please continue to the reverse side and complete.