CONFIDENTIAL

ASSOCIATED ENDODONTISTS
I. ROBERT MATLOFF D.D.S., M.S. LTD.

MEDICAL AND PERSONAL HISTORY

Patient______________________Age______ Spouse______________________________

Address______________________________ Address______________________________

City______________State______Zip________ City______________State______Zip________

Home Phone ( )________Cell Phone ( )________ Home Phone ( )________Cell Phone ( )________

SSN #______________Birth Date__________ SSN #______________Birth Date__________

Employer____________Bus Phone ( )________ Employer____________Bus Phone ( )________

Insurance______________________________ Insurance______________________________

Address______________Phone ( )________ Address______________Phone ( )________

Who referred you to this office______________________________Phone ( )____________

Dentist Name______________Address______________Phone ( )____________

Physician______________Address______________Phone ( )____________

Person to contact in case of emergency ______________________________Phone ( )____________

Is the present problem due to accidental injury? ☐ No ☐ Yes If so, how and when did the accident occur?

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HEALTH HISTORY

1. Have you ever had any of the following: (Check yes or no)

	YES	NO		YES	NO		YES	NO		YES	NO
Heart Trouble	☐	☐	Diabetes	☐	☐	Epilepsy	☐	☐	Blood Disease	☐	☐
High Blood Pressure	☐	☐	Rheumatic Fever	☐	☐	Asthma	☐	☐	Stomach Ulcer	☐	☐
Hepatitis or Liver Disease	☐	☐	AIDS / Exposure	☐	☐	Kidney Disease	☐	☐	Lung Disease / TB	☐	☐
Cancer	☐	☐	Venereal Disease	☐	☐	Major Operation	☐	☐	Hospitalization	☐	☐
Artificial Joints	☐	☐	Heart Murmur	☐	☐	Mitral Valve Prolapse	☐	☐	**Latex Allergy**	☐	☐

2. Have you ever had or ever been told you have had:

	YES	NO		YES	NO
Excessive or prolonged bleeding	☐	☐	A reaction to anesthetic injection ("Novocaine")	☐	☐
An allergic reaction to any drugs	☐	☐	Slow healing of a wound or incision	☐	☐

3. If female, are you pregnant? Yes ☐ No ☐
4. List all present or recent medications ______________________________
5. List all natural or herbal products ______________________________
6. List all medication or drug allergies ______________________________
7. Is there any other information about your health we should know? ______________________________

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I hereby grant permission to Dr. Matloff to administer anesthetics and to employ such operative, surgical, or technical procedures, including X-rays and photographs as many be deemed necessary or advisable in the diagnosis or treatment in the case of the patient whose name appears above. I also authorize Dr. Matloff or any subsequent dentists, to review or copy any and all information that may be contained in this record, to include but not limited to medical history, treatment, and X-rays.

Root canal treatment is an attempt to retain a tooth that may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed . Occasionally a tooth that has had root canal therapy may require retreatment, surgery, or even extraction. I also understand that the root canal filling restores only the root portion of the tooth. The crown portion must be restored by an additional procedure for an additional expense. A monthly 1.5% service charge will be applied on all outstanding balances after 60 days. Should this account become delinquent, I agree to pay all costs of collections.

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Date Signature of Patient, Parent or Guardian