Hilary I. Dunstan, DDS MS

Bruce E. Newcomb, DDS

Boise Endodontics

THE FOLLOWING CONFIDENTIAL INFORMATION IS FOR OUR RECORDS ONLY
(Please Print)

Patient Information

Patient Name ______________________ Age ______________

Date of Birth ______________________ Home Phone ______________

Home Address ______________________ Cell Phone ______________

City ______________________ State ______ Zip Code ______________

Patient Employed By ____

Business Address ______________________ Business Phone ______________

City ______________________ State ______ Zip Code ______________

Spouse Name (Parent if Minor) ______________________ Business Phone ______________

Spouse Employer (Parent if Minor) ______________________ City/St./Zip ______________

Emergency Contact ______________________ Phone ______________

Referring Dentist ______________________ General Dentist ______________

Insurance Information

Primary **Dental** Insurance ______________________ Ins. Phone # ______________

Subscriber Name ______________________ Subscriber # ______________

Subscriber Date of Birth ______________________ Subscriber's Employer ______________

Secondary **Dental** Insurance ______________________ Ins. Phone # ______________

Subscriber Name ______________________ Subscriber # ______________

Subscriber Date of Birth ______________________ Subscriber's Employer ______________

Provided with your insurance information, we will gladly file your insurance claims. ***However, please keep in mind that benefit reimbursement is a contract between you*** and ***your insurance company.*** I authorize the release of my information required by my insurance company. I also authorize payment of benefits directly to the dentist.

Signature Date

PLEASE FILL OUT THE FOLLOWING IF YOU HAVE EXPERIENCED ANY PAIN FROM YOUR TEETH:

Is the pain localized to a definite area of your mouth? ☐ Yes ☐ No

Is it a specific tooth? ☐ Yes ☐ No

Does any particular stimulus produce the pain? – Hot, cold, sweetness, pressure, chewing, lying down, etc.?

Please List: ____

Is the pain described as being sharp, throbbing or a dull ache? ______________________

Does the pain last for seconds, minutes, or is it continuous? ______________________

Does the pain spread to other areas of your mouth or head? ☐ Yes ☐ No

Does the tooth in question feel misaligned or out of position? ☐ Yes ☐ No

When did the toothache start? ______________________

Is there swelling? ☐ Yes ☐ No When did the swelling start? ______________

Did you ever suffer a blow to this area of your mouth? ☐ Yes ☐ No When? ______________

PLEASE COMPLETE MEDICAL HISTORY ON REVERSE SIDE

Medical History

Medical Physician's Name ______________________________

Address ______________________________ Phone ______________

Are you in good health? ❑ Yes ❑ No

Has there been any change in your health in the last year? ❑ Yes ❑ No

Are you presently under the care of a physician? ❑ Yes ❑ No

When was your last medical examination? ______________________________

Have you ever been seriously ill? ❑ Yes ❑ No

Have you ever been hospitalized? ❑ Yes ❑ No

Check any of the following that you have or have had:

❑ Heart Condition	❑ Thyroid/Hormonal	❑ Migraine/Headaches	❑ MVP
❑ Pacemaker	❑ Hepatitis	❑ Epilepsy/Fainting	❑ Heart Murmur
❑ H/L Blood Pressure	❑ Sinusitis	❑ Glaucoma/Visual	❑ HIV/AIDS
❑ Respiratory/Asthma	❑ Tuberculosis	❑ Mental/Neural	❑ Phen/Phen
❑ Rheumatic Fever	❑ Radiation/Chem	❑ Tumor/Neoplasms	❑ Herpes
❑ Jaundice/Liver	❑ Cancer	❑ Alcoholism/Addiction	❑ Other ________
❑ Immunocompromised	❑ Rheumatoid Arthritis	❑ Infectious Diseases	________
❑ Anemia/Bleeding	❑ Osteoporosis	❑ Venereal Disease	________
❑ Diabetes/Kidney	❑ Ulcers/Digestive	❑ Joint Replacement	________

Please list any **ALLERGIES** to medications, foods, materials *(latex, nickel, etc.)* : ______________________________

Are you taking any medications, supplements, herbals, antibiotics or pain medication? ❑ Yes ❑ No

If yes, please list: ______________________________

Do you stop bleeding normally after a cut or injury? ❑ Yes ❑ No

Do you heal normally? ❑ Yes ❑ No

If female, are you pregnant? ❑ Yes ❑ No

The Purpose of endodontic treatment or root canal treatment is an attempt to save a tooth rather than removing it. Although treatment has a high degree of success, it can't be guaranteed. Occasionally, when a tooth has had a root canal treatment, it 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 your treatment completed.

Consent is hereby given to Boise Endodontics and to the treating Endodontist to administer treatment that is deemed necessary. I agree to pay all fees incurred for exams and/or treatment in this office. 1.5% per month will be assessed on all accounts that are over 60 days ($1.00 minimum)

Signature ______________________________ **Date** ______________