Date (M/D/Y)

DAVISVILLE
ENDODONTICS

Welcome To Our Office
In order to aid in evaluating your dental health thoroughly and completely, please complete the following examination questionnaire. This will become part of your office record and will be held in strict confidence.

Patient Information:

☐ Mr. ☐ Mrs. ☐ Ms. _____ _____ _____ _____
First Name Initial Last Name Date of Birth (M/D/Y)

Address _____ Apt. _____ City _____ Postal Code _____

Home Tel ( ) _____ Cell ( ) _____ E-mail _____

Occupation _____ Employer _____ Business Tel ( ) _____

Insurance Information:

Primary Policy Holder Name _____ Policy Holder's D.O.B. (M/D/Y) _____

Insurance Company Name _____ Policy/Group# _____ ID# _____

Secondary Policy Holder Name _____ Policy Holder's D.O.B. (M/D/Y) _____

Insurance Company Name _____ Policy/Group# _____ ID# _____

Name of Spouse/Parent _____ Business Tel ( ) _____

Family Doctor _____ Tel ( ) _____ Referring Dentist _____

Have you ever had an unfavourable reaction following dental treatment? **YES / NO**
Please discuss this with the doctor.

Have you ever had excessive bleeding requiring special treatment? **YES / NO**

Please discuss this with the doctor. **YES / NO**

Female patients, are you or could you be pregnant or nursing? **YES / NO**

If pregnant, which month? _____

List of Allergies

List of Medications & Reason
(include non-prescription drugs)

Check off any of the following which you have or have had:

☐ Heart trouble/Angina
☐ Heart murmur
☐ Asthma
☐ Diabetes
☐ Arthritis
☐ Jaundice
☐ Stroke
☐ Hemophilia
☐ Epilepsy
☐ Glaucoma
☐ Hepatitis A
☐ Addictions
☐ TMJ problems
☐ HIV+/Aids
☐ High blood pressure
☐ Anemia
☐ Rheumatic fever
☐ Lupus
☐ Nervous disorders
☐ Cortisone treatment
☐ Psychiatric treatment
☐ Migraine/Headaches
☐ Emphysema
☐ Herpes
☐ Hepatitis B
☐ Venereal disease
☐ Congenital heart defect
☐ Cardiac pacemaker
☐ Stomach ulcer
☐ Kidney disease
☐ Fainting spells
☐ Sinus trouble
☐ Neck injury
☐ Cancer treatment
☐ Sickle cell disease
☐ Liver disease
☐ Thyroid disease
☐ Alcoholism
☐ Mitral valve prolapsed
☐ Artificial valve, joint/prosthesis
☐ Blood transfusion
☐ Tuberculosis (TB)

Do you have or have you had any other diseases or medical problems not listed on this form? _____

Dental History:

Are you presently in pain? **YES / NO**

Is any part of your mouth sensitive to the following? **YES / NO**

☐ Hot ☐ Cold ☐ Biting Pressure ☐ Sweets
☐ Other _____

Primary complaint: _____

Financial Policy. The major objective of our office is to provide you with the highest quality dental care. Our service is based on a friendly, mutual, but businesslike understanding between doctor and patient. We feel that misunderstanding can be minimized if financial policies are agreed upon at the beginning of treatment.

I hereby state that the above medical history is to the best of my knowledge, accurate and complete. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail. If deemed advisable, I grant permission for my physician to be contacted for details and advice. I further authorize the taking of radiographs or other diagnosticmeasures appropriate for a thorough evaluation.

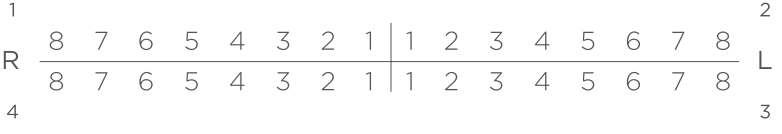
_____ _____
Signed Date

DAVISVILLE
ENDODONTICS

Introducing:

Given Name: _____ Family Name: _____

Appointment Date: ____ ____ _____ Day: S M T W T F S Time: _____ : _____



Patient has been referred for:

- ☐ Non-surgical root canal therapy
- ☐ Surgical root canal therapy
- ☐ Retreatment of previous root canal therapy
- ☐ Emergency treatment will be rendered

I have prescribed the following medications:

- ☐ Antibiotic
- ☐ Analgesic
- ☐ Anti-inflammatory

Patient may be interested in sedation:

- ☐ Yes

Crown/Bridge is cemented:

- ☐ Temporary ☐ Permanently

Filling Required:

- ☐ Temporary ☐ Permanent

Need for full coverage discussed:

- ☐ Yes ☐ No

Post space required:

- ☐ Yes ☐ No

Radiographs:

- ☐ Enclosed ☐ Previously sent

Reason for Appointment:

_____

_____

_____

_____

Referred By: _____ Referral Date: ____ ____ _____

DAVISVILLE ENDODONTICS

Dr. Karam Ashoo DDS, FRCD(C)

Dr. Richard F. Hunter DDS, FRCD(C)

Dr. Veselin Trifonov DDS, MSc

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