BROWARD
ENDODONTICS

The following confidential information is for our records only.
Please answers all questions.

Patient: _____ Birth Date: _____
(please print) last first mi
SS#: _____

If Patient is a minor, Parent's Name: _____

Home Address: _____ H. Phone: _____

City/Zip: _____ Cell. Phone: _____

Parent or Parent Employed by: _____ Bus. Phone: _____

Business Address: _____

Occupation: _____ Email: _____

Spouse's Name: _____ Spouse Employed by: _____

Business Address: _____ Bus. Phone: _____

Occupation: _____

Dental Insurance: ☐ Yes ☐ No Company: _____

Payment Method: ☐ Cash/Check ☐ Visa ☐ MC ☐ Care Credit _____

Name of Dentist: _____ City: _____

Name of Physician: _____ City: _____

HEALTH HISTORY	Yes	No
1. Are you in good health?	☐	☐
2. Have you been treated by a physician during the past five years? If so, please give reason	☐	☐
3. Are you taking any medication now?	☐	☐
4. Are you sensitive or allergic to ☐ anesthetic, ☐ penicillin, ☐ codeine, or any other medication?	☐	☐
5. Have you ever had an unfavorable reaction following dental treatment? If so, please explain.	☐	☐
6. Have you ever had excessive bleeding requiring special treatment?	☐	☐
7. Have you ever had any of the following illnesses?	☐	☐
☐ stroke ☐ heart trouble ☐ high blood pressure ☐ cancer ☐ asthma ☐ tuberculosis ☐ rheumatic fever ☐ diabetes ☐ jaundice ☐ VD ☐ nervous disorder ☐ kidney disease		
8. Have you ever had any other serious illness?	☐	☐
9. Female patients: Are you pregnant? Month	☐	☐
10. Is there any other information that should be known - about your health?	☐	☐
11. Have you ever been infected with Hepatitis or HIV? Please specify.	☐	☐

I, the undersigned, understand that the information on this form is essential to determine my dental needs and the provision of dental treatment; I have read and understand each question, and have answered all of them truthfully and to the best of my ability.

I consent to the performing of whatever procedure may be decided upon to be necessary in the opinion of the doctor, on tooth/teeth #_____. I also understand that upon completion of root canal therapy, I will be referred to my general dentist for permanent crown or filling.

I understand that total payment for the dental services by **Broward Endodontics** is my responsibility and not that of the insurance company, and is due upon completion of treatment.

I understand and agree that in the event that I fail to make payment for services rendered to me, my name and account may be turned over to an attorney or collection agency and I agree to pay said collection agency's fees that may be incurred in the collection of any outstanding balance.

This office reserves the right to charge interest on unpaid balances at the rate of 1.5% per month.

Patient's/Parent's Signature: _____

Reviewed by: _____ Date: _____

DIAGNOSTIC DATA

Subjective Symptoms-

Pain: ☐ present ☐ absent ☐ sharp ☐ dull ☐ localized ☐ diffused ☐ intermittent ☐ continuous ☐ throbbing ☐ referred First noticed _____

Increased by: ☐ cold ☐ heat ☐ biting ☐ pressure ☐ lying down ☐ sweets

Objective Signs & Symptoms-

☐ extraoral swelling	☐ caries	☐ tender to palpation	☐ access open
☐ intraoral swelling	☐ discoloration	☐ tender to percussion	☐ access closed
☐ sinus tract	☐ mobility	☐ crown/bridge	☐ bruxism/clenching
☐ _____	☐ hairline fracture	☐ cusp/crown fracture	☐ TMJ

Radiographic Signs-

☐ normal	☐ radiolucency	☐ internal resorption	☐ root fracture
☐ previous RCT	☐ condensing osteitis	☐ external resorption	☐ root perforation
☐ widened PDL	☐ calcified canals	☐ pulp stones	☐ deep restoration/caries

Etiology-

☐ caries	☐ extensive restoration	☐ idiopathic	☐ occlusion
☐ trauma	☐ periodontal	☐ iatrogenic	☐ cracked tooth

Diagnostic Tests-

tooth	cold	heat	perc	palp	EPT	pocket depth B	L	M	D

Diagnosis-

☐ normal	☐ reversible pulpitis	☐ apical periodontitis	☐ perio/endo
☐ necrosis	☐ Irreversible pulpitis	☐ apical abscess	☐ restorative/endo

Treatment Plan-

☐ NSE ☐ surgery ☐ re-tx ☐ $Ca(OH)_2$ ☐ extraction ☐ observation ☐ root amp ☐ bleaching

Prognosis- ☐ favorable ☐ guarded ☐ questionable ☐ unfavorable

Restoration- ☐ post/core ☐ crown/bridge ☐ amalgam ☐ composite

TREATMENT RECORD

Date	BP:	Pulse:	Tooth canal	ref	TL	Clamp WL	file
			Rad. Exposure Time:				Sec.

Notes - ☐ N_2O ____% ☐ Biteblock ☐ Pillow