Palisades Endodontics Stephen J. Tsoucaris DMD Chart #_____

A: Medical History

Patient Name:_____Date of Birth:_____SS#:_____
Address:_____City/State/Zi[p:_____
Home#:_____Work#:_____Cell #:_____
e-mail:_____@_____
Referred By:_____Dentist Name & Telephone #:_____

Please Complete the following questions in order that we may thoroughly diagnose your condition. The information you provide is for our records and will be considered strictly confidential.

1. Has there been any change in your general health within the past year? YES NO
Please specify _____
2. Are you under the care of a physician for a current problem? YES NO
Please specify _____
3. Have you been hospitalized within the past 5 years? YES NO
Please specify _____
4. Are you taking any medications or drugs? YES NO
Please specify _____
5. Have you received therapy for alcoholism or drug addiction within the past 5 years? YES NO
6. Have you ever had any ALLERGIC OR ADVERSE REACTIONS to anesthetics, antibiotics, or other medications?
_____ YES NO
7. Have you had abnormal bleeding with previous extractions, surgery, or trauma? _____ YES NO
8. Have you ever required a blood transfusion? _____ YES NO
Please explain _____
9. Have you ever had surgery and/or radiation for a tumor, growth, or other condition? _____YES NO
10. Do you have any condition which is infectious? _____ YES NO
11. Date of your last physical exam _____Name of Dr.:_____
12. Do you have any disease or condition, or problem not listed above? _____
Please specify _____
13. Are you required to take antibiotics prior to dental treatment?
14. Have you ever had a root canal? _____Date:_____How was your experience:_____
15. Are you pregnant?_____Are you nursing?_____Do you take birth control pills?_____If you answered Yes, be advised that if you take antibiotics, an alternate method of birth control must be used.
16. Do you or have you had any of the following: (please circle)

High Blood Pressure	Congenital Heart Disease	Heart Murmur or Prolapsed Valve (MVP)
Heart Attack, Stroke, By-Pass Surgery	Pacemaker	Joint Prosthesis (Hip, Knee, Etc.)
Prosthetic Heart Valve	Blood Disorder (eg: Anemia)	Rheumatic Fever or Rheumatic Heart Disease
Hepatitis, Jaundice, Liver Disease	Kidney Problems	Diabetes
Stomach Ulcers, Colitis	Fainting Spells / Epilepsy / Seizures	Veneral Disease
Asthma	Thyroid Problems	Cancer
Psychiatric Treatment	Sinus Trouble	Temporomandibular Joint Problems (TMJ)

17. Are you taking or have you taken: Fen-Phen
18. Are you taking or have you taken: Bisphosphonate use (Actonel, Boniva, Evista, Fosamax)
19. Do you have dental insurance:_____ Insurance Company:_____ Group #:_____
Primary Member SS#:_____Date of Birth:_____
20. Person to contact in case of emergency:_____telephone number:_____

_____ _____ _____
Date: **Signature of Patient*** Signature of Doctor
*All signatures must be by patient or guardian if patient is under the age of 18.

Date:_____BP:_____ P:_____ SaO2:_____

B: ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

You May Refuse to Sign This Acknowledgement

I, _____, have reviewed a copy of this office's Notice of Privacy Practices.

_____ _____ _____
(Please Print Name) **(Signature)** **(Date)**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because.

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify

C: ACKNOWLEDGEMENT OF RECEIPT OF POST OP INSTRUCTIONS:

Post Operative Instructions were given to me both orally & in written form: _____Date:_____ Report Sent_____

Tooth #_____ _____ _____ _____ _____ cc:

Tooth #_____ _____ _____ _____ _____ Perc Palp Perio: ST: HT: Thermal: EPT: