BOONE ENDODONTICS

HOMA AZARGOON, D.D.S
Board Certified Root Canal Specialist
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PATIENT INFORMATION

Patient's Name: _____ Sex: M F Birthdate: _____ Age: _____

SS# _____ Today's Date: _____ If patient is a minor, give parent's or guardian's name: _____

Mailing Address: _____ City_____ State _____ Zip _____

Email Address: _____ Whom may we thank for referring you to our office? _____

Phone: Home _____ Cell _____ Work _____ Ext: _____

Employer/student _____

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM ABOVE)

Name: _____ Mailing Address: _____

Best Contact Phone Number: _____ Relationship to Patient: _____

EMERGENCY INFO

Name: _____

Address:_____

City, State:_____Relationship:_____

Home: _____ Cell Phone:_____

Work Phone: _____ Ext: _____

DENTAL INSURANCE INFORMATION

Policy Holder's Name: _____

Birthdate: _____ SS#: _____

Insurance Co. Name: _____

Address:_____

Insurance Co. Phone:_____

Group #: _____ Policy #: _____

ACKNOWLEDGEMENT OF RECEIPT CANCELLATION POLICY AND NOTICE OF PRIVACY PRACTICES

Cancellation Policy: Since this time is reserved especially for you, your arriving on time is very important. We respect our patient's time and make effort to remain on schedule. When you arrive on time that helps everyone stay on time the rest of the day. Thanks very much for your help.
If you are unable to keep your appointment, we require at least 48 hours notice so that your reserved time may be made available for other patients. If you don't show up or cancel with less than 48 hours notice, you don't give us time to schedule a patient who is waiting to see Dr. Homa. Patients who miss their appointment will be charged a cancellation fee of $50.
I have read and understand the Cancellation Policy and Notice of Privacy Practices for the above named practice.

_____ _____

Signature of patient or legal guardian Date

(see back)

Medical History

	Yes	No
1. Are you under a physician's care for any current health problems?	☐	☐
2. Have you been hospitalized in the last 2 years? If yes, for what? _____	☐	☐
3. Has a physician **(Medical Doctor)** recommended taking a pre-medication prior to dental visits? (Example: joint replacement or heart conditions)	☐	☐
4. Women: Is there a possibility of pregnancy? Expected delivery date _____ Trimester___ OBGYN_____	☐	☐
Are you nursing?	☐	☐
5. Have you ever taken Bisphosphonates (Fosamax)?	☐	☐
Are you still currently taking?	☐	☐

Reason _____ Form: ☐ Tablet ☐ I.V. ☐ Injection

How long was it taken? _____

6. Are you taking Coumadin or Warfarin? If so what is your INR#_____	☐	☐

7. What medications are you currently taking? Please provide list to receptionist if available.

_____

_____

_____

_____

8. Were you prescribed an antibiotic or pain medication for the tooth? If so, what:

_____

9. Okay to take ☐ Ibuprofen ☐ Tylenol

10. Are you allergic to or have you had an adverse reaction to any of the following medication?

	Reaction
☐ Ibuprofen	_____
☐ Codeine	_____
☐ Clindamycin	_____
☐ Nitrous Oxide	_____
☐ Penicillin	_____
☐ Latex (balloons, gloves, etc.)	_____
☐ Household Bleach	_____
☐ Sulfa Drugs	_____

11. Are you aware of being allergic to any other medication or substances? If yes, please list:_____

12. Have you recently traveled outside the US?	☐	☐

HAVE YOU HAD OR DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING:

Yes

☐ AIDS/ HIV positive

☐ Anaphylaxis

☐ Dental Anxiety
Have you taken ☐ Valium ☐ Ativan

☐ Artificial joints
Joint:_____ When _____
Pre-medicate with_____

☐ Shingles

☐ Back/neck problems

☐ Blood disease/ Hemophilia

☐ Cognitive Impairment
☐ Alzheimer's ☐ Dementia

☐ Steroid treatments

☐ Epilepsy

☐ Fainting

☐ Migraines

☐ Herpes

☐ Hepatitis (☐ B or ☐ C)

☐ Sleep Apnea (CPAP or BiPAP)

☐ Diabetes
Type _____
HbA1C# _____
Lasted checked_____
Fasting Glucose Range
_____

☐ Radiation treatment

☐ Chemotherapy

☐ Cancer
Type_____

Remission ☐ Yes ☐ No
Oncologist_____

Yes

☐ Jaw pain
☐ TMJ ☐ Tooth Related

☐ High blood pressure

☐ Glaucoma

☐ Kidney disease/malfunction

☐ Liver disease

☐ Central nervous problems

☐ Psychiatric care
Please Describe _____

☐ Respiratory disease

☐ Chemical dependency

☐ Asthma
Rescue Inhaler? _____

☐ Shortness of breath

☐ Sinusitis

☐ Thyroid disease/malfunction
☐ Hypo ☐ Hyper

☐ Ulcer/Colitis

☐ Stroke
When_____

☐ Angina (chest pains)

☐ Circulatory problems

☐ Pacemaker/heart surgery

☐ Artificial heart valves

☐ Heart Problems (please describe)
_____
_____
_____
_____

☐ Heart attack When_____
Cardiologist _____
Frequency of check ups_____

Consent Statement

I affirm that the information above is accurate and complete to the best of my knowledge. I will not hold Dr. Azargoon or any office member responsible for problems arising from errors or omissions that I made in the completion of this form. I consent to any advisable and necessary endodontic therapy to be administered by Dr. Azargoon and staff for diagnostic purposes or dental treatment. I understand that the consequences of doing nothing might be worsening of the condition, further infection, cystic formation, swelling, pain, loss of tooth, and/or other systemic disease problems.

I understand that root canal treatment is an attempt to save a tooth which otherwise would be lost. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require treatment, surgical intervention or extraction.

Upon completion of root canal therapy, I am to return to my general dentist for the permanent restoration within **4 weeks** or additional treatment may be required or result in necessary removal of the tooth. A temporary restoration is included in the root canal therapy fee; a permanent restoration may be placed here with the approval from your general dentist and an additional fee. **PLEASE INITIAL_____**

If you have any questions, please do not hesitate to ask. We are here to help you.

SIGNATURE_____ Date_____

WITNESS_____ Date_____