Welcome to Kubelka Endodontics

We are pleased to welcome you to our practice. To assist us in serving you, please complete the following form.
If you have any questions, don't hesitate to ask. We look forward to working with you.

Patient Information

Date: _____ Email Address _____

Name _____ Name you prefer to be called: _____
First Name Middle Last Name

Home # _____ Cell # _____ Work # _____

Address _____ City _____ State _____ Zip _____

Soc. Sec.# _____ Date of Birth _____ Age _____ Sex ❑ M ❑ F

Single / Married Spouse's Name_____

Patient Employed by _____ Occupation _____

Your General Dentist _____Who referred you? Dentist or Other _____

Who can we notify in case of emergency? _____ Phone # _____

Tell Us About Your Symptoms (Dental History)

1. The reason for this office visit? _____
2. Prior to this appointment, has root canal treatment been started on this tooth? …… Yes No (Circle One)
3. Do you know of any trauma or injury associated with this tooth or area of the mouth? Yes No
4. Has a recent restoration (filling or crown) been placed on this tooth? …….. Yes No
5. Which area or areas do we need to check for you? (*circle all that apply*) upper right upper left lower right lower left
6. Does it hurt to press the gum tissue around this tooth? Yes / No
7. Do you grind or clench your teeth at night? Yes / No 8. Do you wear a night guard? Yes / N

If you have NEVER experienced any pain or discomfort with this tooth, please skip to Medical Health History.

9. When did you first notice symptoms? _____10. Are you experiencing any pain at this time? Yes No
11. What makes your tooth hurt? (circle all that apply) cold hot sweets chewing hurts spontaneously other _____
12. What is the longest time period that you've experienced this pain ? (#): _____seconds, _____minutes, or _____ hours?

13. Please rate your pain level on a scale of 1 to 10 (circle one). 1------2------3------4-----5------6------7------8------9------10
mild moderate severe

Medical Health History

Physician's Name _____ City _____ Phone _____

Date of last visit _____ Purpose of visit _____

Have you been a patient in the hospital during the past 12 months? Yes / No Reason:_____

Have you been under the care of a physician during the past 12 months? Yes / No Reason: _____

Current Height: _____ft _____in **Weight**: _____lbs

Please complete both sides

Medical Health History continued: Do you have, or have you had, any of the following?

	YES	NO
Heart Problems ----------	❑	❑
Chest pain ----------	❑	❑
Shortness of breath--------	❑	❑
Blood pressure problem--	❑	❑
Heart valve problem-------	❑	❑
Artificial heart valve------	❑	❑
Pacemaker----------	❑	❑
Other _____		
Blood or bleeding problem-	❑	❑
Taking blood thinners-----	❑	❑
Aids / HIV Positive -------	❑	❑
Bruise easily ----------	❑	❑
Allergy Problems ----------	❑	❑
Anaphylaxis ----------	❑	❑
Asthma ----------	❑	❑
Sinus problems ----------	❑	❑
Respiratory Problems ------	❑	❑
Persistent cough ----------	❑	❑
Tobacco habit ----------	❑	❑
Tuberculosis ----------	❑	❑

	YES	NO
Bone or Joint Problems -----❑	❑	
Arthritis ----------	❑	❑
Back or neck pain --------	❑	❑
Joint replacement ---------	❑	❑
Kidney Disease or Problem	❑	❑
Liver Disease or Problem --	❑	❑
Hepatitis (A, B, or C) -----❑		❑
Stomach/Intestinal Problem	❑	❑
Fainting, Seizures, Epilepsy	❑	❑
Stroke(s) ----------	❑	❑
Cancer, chemo? _____	❑	❑
Diabetes ----------	❑	❑
Neurologic Disorder --------	❑	❑
Psychiatric Care ----------	❑	❑

	YES	NO
Alcohol or drug abuse --------	❑	❑
Do you wear contact lenses --	❑	❑
Claustrophobia / problems with things on face?---------	❑	❑
Glaucoma ----------	❑	❑
Women: Pregnant ----------❑		❑
if so, due date _____		
Nursing ----------❑		❑

Please list below any disease, condition, or problem not already disclosed:

_____

_____

_____

_____

Allergic to: (Circle) Aspirin Codeine Hydrocodone Latex Penicillin Clindamycin Local Anesthetic Other_____

Have you taken any medications for osteoporosis such as: Fosamax Actonel Evista Boniva other_____

List medications you are currently taking, including any antibiotics, pain medicine or Herbs: _____

_____

_____

Do you feel nervous about having dental treatment? Yes No Have you ever had a bad experience in a dental office? Yes No

Are you interested in the following sedation options: 1) nitrous oxide (laughing gas), 2) pill sedation (halcion), or 3) IV sedation (sleep dentistry with an anesthesiologist)?

Authorization: I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that the doctor will use this information in order to determine appropriate and healthful endodontic treatment. If there is a change in my medical status, I will inform the endodontist. I authorize the doctor or his staff to take x-rays and the doctor to do an examination in order to diagnose my condition. I authorize the release of any information including the diagnosis and records of any examination and/or treatments rendered, to any other health care providers, such as my dentist or physician, who may be involved in my care. I authorize the insurance company indicated on this form to pay the endodontist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the endodontist to release all information necessary to secure the payment of benefits. Payment is due in full at time of treatment, unless prior arrangements have been approved.

I understand that I am financially responsible for all charges whether or not paid by insurance.

I have read and understand HIPPA privacy regulations as they pertain to my dental care at Kubelka Endodontics.

Patient, Parent, or Legal Guardian Signature_____ Date _____

Please Print Name_____ Relation to patient _____ Dr. Initial _____