The following confidential information is for our records only. Please print:

Mr.
Ms.
Mrs.
Miss ____ Age ____________
first name middle initial last name

Home Address ______________________________________ Phone ( ) ____________
street

____ Cell ( ) ____________
city zip

Birth Date ____________ Drivers License No ____________ Soc. Sec. No. ____________

Patient Employed By ______________________________ Occupation ____________

Business Address __________________________________ Phone ( ) ____________

Name of Spouse (or, if minor,
person legally responsible) ____________________________ Phone ( ) ____________

Spouse (or, if minor, person
legally responsible) Employed by ________________________ Phone ( ) ____________

Name of Dental Insurance Company ____

Insured Name ______________________ BirthDate ____________ ID# ____________

Please feel free to discuss treatment cost prior to treatment being rendered. Either the front desk staff or the treating doctor will be happy to discuss any aspects of your treatment.

The total payment of the fee for professional services rendered by Dr. Thomas J. Rauth, Dr. Bradley G. Seto, Dr. Richard J. Rauth or Dr. Brandon G. Seto is the patient's responsibility. As a courtesy, insurance forms will be completed without charge.

Name of family Physician ______________________ Address ______________________

Name of your Dentist ______________________ Address ______________________

Referred by ____

Other Dental Specialists you have consulted, if any ______________________________

HEALTH HISTORY

Please answer each question

Are you in good health? .... Yes No

Are you being treated by a physician for any reason? .... Yes No

If Yes, explain ____

Are you allergic to or have you had an adverse reaction to any drugs or medication? .... Yes No

If Yes, explain ____

Are you allergic to latex? .... Yes No

Are you subject to abnormal bleeding or bruising? .... Yes No

Have you had or been treated for nervous disorders, fainting, dizziness, numbness, weakness or seizures?
If yes, circle which? .... Yes No

Have you had or been treated for hepatitis, venereal disease, HIV, AIDS, tuberculosis, or rheumatic fever?
If yes, circle which? .... Yes No

Have you had or been treated for heart trouble, chest pain, high blood pressure, breathing difficulty or asthma?
If yes, circle which? .... Yes No

Have you had or been treated for liver disorders, kidney problems, ulcers, intestinal problems or diabetes?
If yes, circle which? .... Yes No

Do you have a heart murmur, mitral valve prolapse, artificial heart valve, pacemaker, artificial joint or other implanted prosthesis?
If yes, circle which? .... Yes No

Have you ever taken bisphosphonate medication? e.g. Fosamax, Zometa, Actonel, Boniva, Prolia. .... Yes No

Have you ever taken RANKL inhibitors? e.g. Xgeva, Denosumab. .... Yes No

Are you taking any medications at present? .... Yes No

Name of medication? ____

What condition is being treated? ____

Have you had an unfavorable reaction from previous dental treatment or dental anesthetic? .... Yes No

Do you have difficulty opening or keeping your mouth open? .... Yes No

Do you have a history of TMJ problems or jaw pain? .... Yes No

Female Patients: Months Pregnant ________ Obstetrician ______________________________
name phone

Root canal treatment is an attempt to retain a tooth which may otherwise require extraction. 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 retreatment, surgery, or even extraction.
Upon completion of root canal therapy in this office, you should return to your general dentist for permanent restoration such as a crown, cap, onlay or filling.

Date ______________________ Signature ______________________________________

* Parent Signature if Patient Under Age 18