JAMES R. STEPHENS, D.D.S., M.Sc.D., ENDODONTICS

NAME: ______________________________ M/F **PHONE:** __________ **CELL:** __________
LAST FIRST M.I.
E-MAIL: ______________________________

HOME ADDRESS: ______________________________ (CITY) __________ (ZIP CODE) __________

DATE OF BIRTH: __________ AGE: ______ (**FOR MINORS, PARENT:** ______________________________)

OCCUPATION: ______________________________ EMPLOYED BY: __________ **PHONE:** __________

SPOUSE'S NAME: ______________________________ DATE OF BIRTH: __________

SPOUSE'S OCCUPATION: ______________________________ EMPLOYED BY: __________ **PHONE:** __________

NEAREST RELATIVE OR FRIEND? ______________________________ **PHONE:** __________

REGULAR DENTIST: ______________________________ **PHONE:** __________

PATIENT'S DENTAL INSURANCE ______________________________ ______________________________
SOCIAL SECURITY NUMBER

SPOUSE'S DENTAL INSURANCE ______________________________ ______________________________
SOCIAL SECURITY NUMBER

HEALTH HISTORY

ARE YOU IN GOOD HEALTH? ______________________________

ARE YOU CURRENTLY UNDERGOING MEDICAL TREATMENT OF ANY KIND?

DESCRIBE ______________________________

PHYSICIAN ______________________________ PHONE: __________

	YES	NO
1. Have you been treated by a physician during the past 5 years?	______	______
2. Are you sensitive or allergic to Novocaine, Penicillin, Codeine, Sulfa, Latex, or any other medication?	______	______
3. Are you taking any medication now? Please list ______________________________	______	______
4. **Do you take Aspirin daily?**	______	______
5. Have you ever had an unfavorable reaction following dental treatment?	______	______
6. Do you usually require extra anesthetic?	______	______
7. Have you ever had a stroke, heart trouble, high blood pressure, rheumatic fever, asthma, tuberculosis, hepatitis, jaundice, kidney trouble, diabetes, epilepsy, nervous disorders, excessive bleeding, ulcers, glaucoma, or any other serious illness? *(Please circle all that apply)*	______	______
8. Female patients: Are you pregnant? Which month?	______	______
9. Have you had an artificial prosthesis, hip replacement, heart valves?	______	______
10. Are you wearing a pacemaker?	______	______
11. Have you been tested for HIV (Human Immunodeficiency Virus)? . . . . A. Test Date __________ Result __________	______	______
12. Have you ever had a blood transfusion?	______	______
13. Is there any medical condition, not listed above, that we should be made aware of?	______	______

CONSENT FOR TREATMENT

I, the undersigned, being the patient, or parent or guardian of the aforementioned minor patient, consent to receive special consultation and, should I agree to accept treatment, I also consent to the performing of whatever procedure may be necessary including such drugs and/or anesthetics as may be deemed advisable by the Doctor. **I also understand that only the root canal treatment will be done in this office. The permanent restoration (filling, crown, onlay, etc.) will be done by my regular dentist.**

I acknowledge full responsibility for the payment of such services and agree to pay for them in full, by or before completion, unless other specific arrangements are made with the receptionist.

Patient's / Parent's Signature: ______________________________ Date: __________

A. CHIEF COMPLAINT

- ☐ None
- ☐ Pain to heat
- ☐ Pain to cold
- ☐ Pain to biting pressure
- ☐ Pain without provocation
- ☐ Steady toothache
- ☐ Throbbing
- ☐ Just aware of it
- ☐ Drainage
- ☐ Discoloration
- ☐ Pain when lying down
- ☐ Swelling
- ☐ Pain to sweets
- ☐ Severity 1 to 10 _____
- ☐ __________________

NAME: ______________________ REFERRING DENTIST: ______________________

TOOTH												
PERCUSSION												
ELECTRIC TEST												
COLD												
HOT												
CAVITY												
ANESTHETIC												
COTTON ROLL												
PALPATION												

E. TREATMENT PLAN
1. non surgical root canal treatment
2. surgical root canal treatment
   curettage
   apicoectomy
   retrograde amalgam
   root section / amputation
   intentional replant
3. apexogenesis
4. apexification
5. no treatment

C. RADIOGRAPHIC SIGNS
- Normal ☐
- Caries ☐
- Widened PDL ☐
- PA radiolucency ☐
- PA radiopacity ☐
- Calcification ☐
- Root fracture ☐
- Open Apex ☐
- Perforation ☐
  1. iatrogenic ☐
  2. resorption ☐
- Internal resorption ☐
- External resorption ☐
  1. apical ☐
  2. lateral ☐
- LEO furcal ☐
  - lateral ☐
  - infrabony ☐
- Broken instrument ☐
- Previous RCT ☐
  1. silver cone ☐
  2. gutta percha ☐
  3. indistinguishable ☐
  4. SRCT ☐
- Post ☐

F. POST SPACE & BUILD UP
1. No post space
2. Post space only
3. Post and build up

G. FEE

D. DIAGNOSIS
1. reversible pulpitis
2. irreversible pulpitis
3. necrosis
4. acute alveolar abscess
5. lesion of endodontic origin
6. normal
7. cracked tooth syndrome
8. calcific degeneration
9. endodontic failure
10. perforation

H. PATIENT INFORMED
1. prognosis ______
2. restoration needed ☐
3. cuspal coverage needed ☐
4. periodontal treatment needed ☐
5. ______

DATE MO / DAY / YEAR	TOOTH	RECORD OF TREATMENT