EDWIN LEVY, **D.D.S., Cert. Endo.** **ENDODONTIST**

Patient: ____________________ Date of Birth____________
Given Name Family Name D M Y

Home Address: ____________________
Street City Postal Code

Home Phone: ____________ Business Phone: ____________ Cell Phone: ____________

Health Card #:____________________

If patient is a minor, who is legally responsible: ____________________

Referring Dentist: ____________________

Family physician: ____________________

Name of Dental Insurance Co. #1____________________ Subscriber #1:____________

Group No.__________ Your CERT. No. or I.D. No.____________________

Name of Dental Insurance Co. #2____________________ Subscriber #2:____________

Group No.__________ Your CERT. No. or I.D. No.____________________

I understand that the total payment of the dental service is my responsibility and not that of the insurance company. (We will be happy to complete any insurance form so that you may be reimbursed by your insurance company.) Unless prior arrangements are made. payment is due when services are rendered.

HEALTH HISTORY

	YES	NO
1. Do you require premedication prior to dental treatment?	_____	_____
2. Do you have a cardiac pacemaker or artificial heart valve?	_____	_____
3. Are you sensitive or allergic to Novacaine, Penicillin, Codeine, Latex or any other medication?	_____	_____
4. Are you taking any medication?	_____	_____
5. Have you ever had an unusual reaction to any medicine or anaesthetic?	_____	_____
6. Have you ever had excessive bleeding or delayed healing following an injury or dental surgery?	_____	_____

7. Have you ever had any of the following illnesses? If so, please circle.

Stroke	Heart condition	High blood pressure	AIDS	Rheumatic fever
Dizziness	Asthma	Hepatitis	Jaundice	Tuberculosis
Diabetes	HIV Pas.	Kidney disease	Epilepsy	Nervous disorders

Any other ____________________

8. Have you had any serious illness? ____________________ _____ _____

Female patients: Are you pregnant? __________ Which month?____________

PERMISSION FOR ROOT CANAL TREATMENT AND LOCAL ANAESTHETIC

I, the undersigned, being the patient, parent or guardian of the above minor patient, consent to the performing of whatever procedure may be determined necessary or advisable, in the opinion of the Doctor. A report of treatment will be sent to my referring dentist. I also understand that upon completion of root canal therapy in this office I will be referred to my general dentist for permanent restoration such as crown, cap, jacket, on lay or filling.

Patient's/Parent's Signature: ____________________ Date:____________