Honolulu Endodontics Inc.
1401 S. Beretania Street, Suite 480 | Honolulu | Hawaii | 96814 | 808-597-1221

Welcome!

Thank you for choosing our practice. Our goal is to make your visit as pleasant as possible. Please fill out this form completely so we can serve you better.

PATIENT INFORMATION

Name_____ [ ] Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Other
First MI Last

Address_____ Occupation:_____ [ ] Male [ ] Female

City_____ State_____ Zip Code_____ Hm# (____)_____

Employer_____ Wk# (____)_____

Are you [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated Cell# (____)_____

DOB:_____/_____/_____ SSN#_____ E-mail:_____

Spouse's Name _____ Spouse occupation_____
First MI Last(if different) Cell #: _____

DOB:_____/_____/_____ SSN#_____ Work #:_____

Is patient a full time student? [ ] No [ ] Yes : Name of School:_____

REFERRAL INFORMATION

Whom may we thank for referring you?_____ Your Dentist's Name:_____

RESPONSIBLE PARTY INFORMATION (if different than patient)

Name_____ Relationship_____
First MI Last
Hm# (____)_____

Address_____ Wk# (____)_____

City_____ State_____ Zip Code_____ Cell# (____)_____

DOB:_____/_____/_____ SSN#_____ E-mail:_____

INSURANCE INFORMATION

MEDICAL INSURANCE:

Subscriber's Name_____ Relationship to patient_____

DOB: _____/_____/_____ Subscriber's SSN#_____

Insurance Company_____ Policy#_____ Group#_____

DENTAL INSURANCE

Insured Name_____ Relationship to patient_____

Address_____ City_____ State_____ Zip Code_____

DOB:_____/_____/_____ SSN#_____ Employer_____

Insurance Company_____ Subscriber ID#_____ Grp#_____

MEDICAL INFORMATION

Emergency Contact Information: Name:_____ Relationship:_____

Home #_____ Work# _____ Cell# _____

Physicians Information:

Physician Name: _____ Physician Phone: _____

Specialist Name: _____ Specialist Phone: _____

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Medical History Cont'd

[ ] Yes [ ] No [ ] Unknown **1)** Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth?

[ ] Yes [ ] No [ ] Unknown **2)** Has there been any change in your general health within the past year? If yes, explain.

_____

[ ] Yes [ ] No [ ] Unknown **3)** Are you under the care of a physician for a current problem? If yes, explain.

_____

[ ] Yes [ ] No [ ] Unknown **4)** Have you been hospitalized within the past 5 years? Please specify.

_____

[ ] Yes [ ] No [ ] Unknown **5)** Have you received therapy for alcoholism or drug addiction during the past 5 years?

[ ] Yes [ ] No [ ] Unknown **6)** Have you ever had any **ALLERGIC** or **ADVERSE REACTIONS** to anesthetics/antibiotics/medications?

_____

[ ] Yes [ ] No [ ] Unknown **7)** Is there any condition concerning your health that the doctor should be told?

[ ] Yes [ ] No [ ] Unknown **8)** Do you wish to speak to the doctor privately about anything?

[ ] Yes [ ] No [ ] Unknown **9)** Have you had abnormal bleeding with previous extractions, surgery, or trauma?

[ ] Yes [ ] No [ ] Unknown **10)** Have you ever required a blood transfusion?

[ ] Yes [ ] No [ ] Unknown **11)** Have you ever had radiation for any condition?

[ ] Yes [ ] No [ ] Unknown **12)** Have you ever tested positively for HIV infection or AIDS? If so, state date diagnosed and treating Dr.

_____

[ ] Yes [ ] No [ ] Unknown **13)** Are you required to take antibiotics prior to dental treatment?

14) Do you have, or have you had any of the following?

[ ] High blood pressure
[ ] Heart murmur or prolapsed valve
[ ] Joint prosthesis(hip, knee, etc.)
[ ] Congenital Heart disease
[ ] Prosthetic heart valve
[ ] Blood disorder (e.g. anemia)
[ ] Venereal disease
[ ] Asthma
[ ] Allergy to latex
[ ] Low blood pressure
[ ] Chest pain, angina
[ ] Swollen ankles, arthritis or joint disease
[ ] Cardiac pacemaker
[ ] Heart Surgery
[ ] Delay in healing
[ ] Tuberculosis
[ ] Emphysema
[ ] X-ray treatment or chemotherapy
[ ] On a diet
[ ] History of alcohol abuse
[ ] *Eye disease or glaucoma*
[ ] Infectious mononucleosis

[ ] Sinus Problems
[ ] Thyroid problems
[ ] Diabetes
[ ] Stomach ulcers, colitis
[ ] Hepatitis, jaundice, liver disease
[ ] Kidney problems
[ ] Psychiatric treatment
[ ] Fainting spells or seizures
[ ] Epilepsy
[ ] *Cancer*
[ ] TMJ - Temporomandibular joint problems
[ ] Low blood sugar
[ ] Dialysis
[ ] Irregular heart beat
[ ] Contagious diseases
[ ] Bronchitis, chronic cough
[ ] Hay fever
[ ] Problems with the immune system
[ ] Difficult breathing or other lung trouble
[ ] Chronic fatigue or night sweats
[ ] *History of drug abuse*
[ ] Bruise easily [ ] Gallbladder trouble

[ ] Yes [ ] No [ ] Unknown **15)** Do you have any disease, condition or problem not listed above? Specify.

_____

[ ] Yes [ ] No [ ] Unknown **16)** Are you taking any medications or drugs? If yes, please list them below:

_____

WOMEN ONLY:

[ ] Possibility of pregnancy Estimated delivery date:_____
[ ] Nursing [ ] Taking birth control pills

INJURY: [ ] This visit is related to an accident [ ] Work related Date of Injury:_____

Insurance company:_____ Claim Number: _____

Name of Attorney/Adjustor:_____ Attorney/Adjustor Phone# _____

I understand that the above information is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform Honolulu Endodontics, Inc. of any changes in my medical status. I authorize release of medical information if necessary.

Signature: Date:

Honolulu Endodontics Inc
1401 S Beretania St., Ste. 480 | Honolulu | Hawaii | 96814
O: 808-597-1221 | F: 808-591-2070 | Email: honoluluendo@gmail.com

Patient's Name: _____ Date:_____Tooth:_____

1) Have you experienced pain in this tooth at any time in the past?
☐ Yes ☐ No

2) Are you in PAIN now?
☐ Yes ☐ No

3) If your are in pain now, how long have you been in pain?
☐ 1 day ☐ 2 days ☐ 3 days ☐ 4 days ☐ 5 days
☐ 6 days ☐ 1 week ☐ 2 weeks ☐ 3 weeks ☐ > 3 weeks

4) Did this pain either keep you awake or awaken you last night?
☐ Yes ☐ Yes, and I have been up all night in pain
☐ No ☐ No, but it has before

5) Can you locate the tooth that is causing the pain?
☐ Yes ☐ No ☐ Not sure
☐ There may be more than one tooth

6) Does the pain radiate to the other parts of your jaw or your neck and shoulders?
☐ Yes ☐ No ☐ Not now but has in the past

7) Is the pain spontaneous or does it always require some stimulus to become painful?
☐ I have spontaneous ☐ It always take some stimulus to make it hurt
☐ I don't have spontaneous pain now, but have in the past with this tooth

9) How would you rate the severity of your pain today?
(Please circle as to 10 being unbearable and 1 being very slight)
1 2 3 4 5 6 7 8 9 10

11) Please check the frequency and nature of pain that most closely describes your discomfort:
☐ Sharp ☐ Dull ☐ Radiating
☐ Throbbing ☐ Migrating ☐ Constant
☐ Aching ☐ Intermittent ☐ Momentary
☐ Gnawing ☐ Variable ☐ Enlarging to other areas
☐ Shooting ☐ Tingling ☐ Itching
☐ Burning ☐ Only when chewing or biting

12) Is the tooth sensitive to temperature in the past?
☐ No, but there is a history of temperature In the past
☐ More to hot than cold ☐ Equally to hot and cold
☐ Neither ☐ Not sure ☐ More sensitive to cold than hot

13) What relieves the pain?
☐ Nothing ☐ Cold ☐ Hot ☐ Massage ☐ Vicodin
☐ Non- Biting ☐ Aspirin ☐ NSAIDS ☐ Codeine ☐ Advil/Aleve
☐ Antibiotics ☐ Other ☐ Davron/Darvocet ☐ Tylenol

14) If you don't touch the tooth or bite on it, does it still hurt?
☐ Yes ☐ No ☐ Sometimes
☐ Only if I bite in a certain way
☐ Not now, but it has in the past

15) What increases the pain?
☐ Touching ☐ Biting ☐ Cold ☐ Hot ☐ Eating
☐ Lying down ☐ Pressing on gum ☐ Flossing ☐ Nothing

16) What is the course of the pain? (Please Circle)
Increasing Decreasing Constant Variable None Now

17) Has there been any recent work done on this area?
☐ Yes ☐ No ☐ Not sure

_____
Patient's Signature **Date**