HONOLULU
ENDODONTICS

1401 S. Beretania Street, Suite 480
Honolulu, HI 96814

PATIENT INFORMATION Please print legibly

[ ]Dr. [ ]Mr. [ ]Mrs. [ ] Ms. [ ]Other	First Name:	Last Name:	M.I.
Home Phone ( )	Cell Phone ( )	Date of Birth:	
Work Phone ( )	Nickname:	Gender [ ]Male [ ]Female	
Driver's Lic. #:	Email:		
Mailing Address:	City/State/Zip:		
Home Address:	City/State/Zip:		
General Dentist:	Referred By:		
Employer Name:	Occupation:		
Employer Address:	Work Number:		
In case of emergency, please contact:	Phone #:	Relationship to Patient:	

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT...

[ ] Self (If self, skip this section) [ ] Spouse [ ] Father [ ] Mother [ ] Other			
Name:	S.S.#:	Birth Date:	Phone #:
Address:	City:	State:	Zip Code:
Employer:	Business Phone:	Email:	

DENTAL INSURANCE INFORMATION

Do you have dental insurance? [ ] Yes [ ] No

DENTAL INFORMATION

1. Have you experienced pain with this tooth at any time in the past? [ ] Yes [ ] No
2. Are you in PAIN now? [ ] YES [ ] NO
3. If you are in pain now, for how long have you been in pain? [ ] 1-3 Days [ ] 1 Week [ ] 2 Weeks [ ] 3 Weeks
4. Can you locate the tooth that is causing the pain? [ ] Yes [ ] No [ ] Not Sure [ ] More than 1 tooth
5. Is the pain spontaneous? [ ] Yes [ ] No
6. Do you feel swollen now? [ ] Yes [ ] No Has there been a history of prior swelling? [ ] Yes [ ] No
7. 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
8. Do you have lingering pain? [ ] Yes [ ] No

9. Please circle the nature of pain that describes your discomfort (Please Circle):

Sharp	Shooting	Variable	Momentary	Constant
Throbbing	Dull	Tingling	Itching	
Aching	Migrating	Radiating	Burning	
Gnawing	Intermittent	Only when chewing or biting		

10. Is tooth sensitive to temperature? [ ] Hot [ ] Cold [ ] Both [ ] Neither

11. What increases the pain? (Please Circle)

Touching	Pressing on gum	Hot/Cold
Lying Down	Cold Air	Flossing
Eating	Sweets	Biting

12. What is the course of the pain? [ ] Increasing [ ] Decreasing [ ] Constant [ ] Variable

Y	N	13. Has there been any recent restorative work done in this area?
Y	N	14. Have you taken any antibiotics for this problem?
Y	N	15. Have you taken any pain medication for this problem?
Y	N	16. Did your Doctor recommend this referral?

MEDICAL HISTORY INFORMATION

Y	N	1. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If yes, please explain.
Y	N	2. Has there been any change in your general health within the past year?
Y	N	3. Are you under the care of a physician for a current problem?
Y	N	4. Have you received therapy for a alcoholism or drug addiction during the past 5 years?
Y	N	5. Is there any condition concerning your health that the doctor should be told?
Y	N	6. Have you ever required a blood transfusion?
Y	N	7. Have you ever had radiation for any condition?
Y	N	8. Have you ever tested positive for HIV or AIDS? If yes, date & treating Doctor?
Y	N	9. Are you required to take antibiotics prior to dental treatment?

10. Do you have or have you had any of the following?

☐ High blood pressure	☐ Heart murmur or prolapsed valve	☐ Joint prosthesis (hip, knee, etc.)
☐ Rheumatic fever or rheumatic heart disease	☐ Congenital heart disease	☐ Cardiovascular disease, heart attack, stroke
☐ Prosthetic Heart Valve	☐ Blood disorder (e.g. anemia)	☐ Veneral disease
☐ Asthma	☐ Swollen ankles or joint disease	☐ Low blood pressure
☐ Chest Pain, Angina	☐ Delay in healing	☐ Cardiac pace maker
☐ Heart Surgery	☐ X-ray treatment or chemotherapy	☐ Tuberculosis
☐ Emphysema	☐ Eye disease or Glaucoma	☐ On a diet
☐ History of alcohol abuse	☐ Thyroid problems	☐ Infectious mononucleosis
☐ Sinus trouble	☐ Hepatitis, jaundice, liver disease	☐ Diabetes
☐ Stomach ulcers, colitis	☐ Fainting spells or seizures	☐ Kidney problems
☐ Psychiatric treatment	☐ Temporomandibular joint problems (TMJ)	☐ Epilepsy
☐ Cancer	☐ Irregular heart beat	☐ Low blood sugar
☐ Dialysis	☐ Hay fever	☐ Contagious disease
☐ Bronchitis, Chronic cough	☐ Chronic fatigue or night sweats	☐ History of drug abuse
☐ Difficult breathing or lung trouble	☐ Bruise easily	☐ Gallbladder trouble
☐ Wear contact lenses		☐ Other:

11. Have you ever had an allergic reaction or sensitivity to:

- ☐ No Known Allergies
- ☐ Dental Anesthetics
- ☐ Sulfa
- ☐ Latex
- ☐ Tetracycline
- ☐ Other
- ☐ Aspirin
- ☐ Codeine
- ☐ Penicillin
- ☐ Erythromycin
- ☐ Bleach

WOMEN ONLY

Possibility of pregnancy: YES / NO	Nursing: YES / NO
Estimated delivery date:	Taking birth control pills: YES / NO
Note: Antibiotics may alter the effectiveness of birth control pills. Please consult with your physician/gynecologist for assistance regarding additional methods of birth control.	

I certify 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 personal and medical status. I authorize release of medical information if necessary. I will not hold my doctor, or any member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Patient Name (Please Print)_____

_____ _____

Patient Signature (Parent signature if patient is under 18 years of age). **Date**