

NORWELL ENDODONTICS

Kathy Alikhani, D.M.D.

353 Washington Street

Norwell, MA 02061

• 781.561.7400 • fax: 781.561.7402

email: kathyalikhani@norwellendodontics.com

CONTACT INFORMATION

Please complete the following pages by either; 1.) typing in the areas to be completed & clicking check boxes, then print out; 2.) print these pages and manually fill in; 3.) bring the completed forms to the doctor's office on your next visit. Please call the office if you have any concerns or questions.

First Name: _____ MI: _____

Last Name: _____

Salutation: Mr. _____ Mrs. _____ Ms _____ AKA: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Phone (H): _____ Phone (W): _____

Phone (Cell): _____ Fax: _____

SS#: _____ Birthdate: _____

Age: _____ Gender: Male _____ Female _____

Referred by: _____ Gen. Dentist: _____

Additional doctor: _____

Occupation: _____

Employer Name: _____

Employer Address: _____

Emergency Contact: _____ Spouse: _____

Guarantor: _____ Legal Guardian: _____

Other Contact: _____

Email Home: _____ Email Work: _____

Insurance Company: _____

Subscriber: _____ Date of Birth: _____

Subscriber ID: _____ Group Number: _____

MEDICAL HISTORY INFORMATION

Height: _____ Weight: _____ Date of last physical exam: _____

Yes No 1. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around mouth?

If yes, explain. _____

Yes No 2. Has there been any change in your general health within the past year? If yes, explain. _____

Yes No 3. Are you under the care of a physician for a current problem? If yes, explain.. _____

Yes No 4. Have you been hospitalized within the past 5 years? Please specify. _____

Yes No 5. Have you received therapy for alcoholism or drug addiction during the past 5 years?

Yes No 6. Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetics/antibiotics/ medications?

Yes No 7. Is there any condition concerning your health that the doctor should be told?

Yes No 8. Do you wish to speak to the doctor privately about anything?

Yes No 9. Have you had abnormal bleeding with previous extraction's, surgery or trauma?

Yes No 10. Have you ever required a blood transfusion?

Yes No 11. Have you ever had surgery and/or radiation for a tumor, growth, or other condition?

Yes No 12. Have you ever tested positively for HIV infection or AIDS? If so state date diagnosed and treating Dr.

Yes No 13. Are you required to take antibiotics prior to dental treatment?

Yes No 14. Do you have, or have you had any of the following? Check all that apply.

High blood pressure

Heart murmur or prolapsed valve

Sinus trouble

Thyroid problems

Joint prosthesis (hip, knee, etc.)

Rheumatic fever or rheumatic heart disease

Congenital heart disease

Cardiovascular disease: heart attack, stroke or bypass

Prosthetic heart valve 0 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

Diabetes

Stomach ulcers, colitis

Hepatitis, jaundice, liver disease

Kidney problems

Psychiatric treatment

Fainting spells or seizures

Epilepsy

Cancer

Temporomandibular Joint problems (TMJ)

Low blood sugar

Dialysis

Irregular heart beat

Contagious diseases

Bronchitis, chronic cough

Hay fever or sinus problems

Problems with the Immune system

Difficult breathing or other lung trouble

Chronic fatigue or night sweats

History of drug abuse

Wear contact lenses

Bruise easily

Gallbladder trouble

- Yes No 15. Are you taking any herbal medicine (i.e., St. Johns Wort)?
- Yes No 16. Have you ever taken the “fen-phen” diet?
- Yes No 17. Do you have any disease, condition or problem not listed above? Specify.
- Yes No 18. Are you taking bisphosphonates now or have you ever taken them in the past (Fosamax)?
- Yes No 19. Are you taking any medication or drugs? If yes, please list them Below.

Date:	Dosage:	Frequency	Medication Prescribed	Reason for Taking

WOMEN ONLY:

Possibility of pregnancy: Yes No Estimate delivery date: _____

Nursing: Yes No Taking birth control pills: Yes No

Women Note: *Antibiotics such as Penicillin may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.*

INJURY:

This visit is related to an accident Work Related _____

Date of injury: _____

Insurance Company handling the Claim: _____

Claim Number: _____

Name of Attorney / Adjustor: _____

Attorney / Adjustor Telephone: _____

PHYSICIANS INFO:

Physician Name: _____

Phone: _____

Specialist Name: _____

Phone: _____

Patient's Signature: _____ Date: _____

DENTAL HISTORY FORM:

What brings you to our office today? _____

Are you in pain now? Yes No How long have you been in pain? _____

On a scale of 0 to 10 how severe is the pain? _____

Can you locate the tooth that is causing the pain? _____

Is the pain constant _____ or intermittent _____? Does the pain keep you up at night? _____

Have you had any recent dental work done in the area? _____

What increases the pain? Hot _____ Cold _____ Pressure _____ Sweets _____ Everything _____

Prior to this appointment has endodontic treatment been started by any doctor? _____
