

TOOTH AND PAIN HISTORY

I have been referred for Tooth #_____, or Area: Upper Rt / Lower Rt / Upper Lt / Lower Lt / Front Upper / Front Lower

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| <input type="checkbox"/> 1. I am here for treatment of present pain.
<input type="checkbox"/> 2. I have had pain.
<input type="checkbox"/> 3. I have never had pain.
<input type="checkbox"/> 4. I am here for consultation ONLY .
<input type="checkbox"/> 5. I am here for treatment of abscess.
<input type="checkbox"/> 6. My dentist said I need root canal therapy.
<input type="checkbox"/> 7. My dentist worked on the tooth.
When: _____
<input type="checkbox"/> 8. I have had many fillings on this tooth.
<input type="checkbox"/> 9. This tooth was crowned <input type="checkbox"/> once <input type="checkbox"/> twice.
<input type="checkbox"/> 10. I have had my teeth straightened.
<input type="checkbox"/> 11. I have had an accident involving this tooth.
<input type="checkbox"/> 12. I have had surgery on this tooth.
<input type="checkbox"/> 13. I have had gum surgery in this area..
<input type="checkbox"/> 14. I have had root canal therapy on this tooth
by Dr. _____ When: _____
<input type="checkbox"/> 15. When drilling the tooth, the dentist reached the
nerve, or very close to it.
<input type="checkbox"/> 16. The tooth was filled or crowned on _____
<input type="checkbox"/> 17. The dentist is planning to replace the present
crown or bridge.
<input type="checkbox"/> 18. I first notice the pain: _____ days
_____ weeks _____ months ago.
<input type="checkbox"/> 19. The pain is steady.
<input type="checkbox"/> 20. The pain comes and goes.
<input type="checkbox"/> 21. The pain is getting worse.
<input type="checkbox"/> 22. The pain is decreasing or has disappeared. | <input type="checkbox"/> 23. The pain occurs spontaneously.
<input type="checkbox"/> 24. The pain is associated with eating or chewing.
<input type="checkbox"/> 25. The pain has localized on one tooth.
<input type="checkbox"/> 26. The pain occurs at night.
<input type="checkbox"/> 27. The pain occurs then lingers on.
<input type="checkbox"/> 28. The pain is increased by cold.
<input type="checkbox"/> 29. The pain is increased by heat.
<input type="checkbox"/> 30. The tooth feels elongated and sore to touch.
<input type="checkbox"/> 31. The gum and jaw are painful.
<input type="checkbox"/> 32. The pain is spreading to the ear.
<input type="checkbox"/> 33. The pain is spreading to the neck.
<input type="checkbox"/> 34. The pain is spreading to the eye.
<input type="checkbox"/> 35. The whole side of my face is painful.
<input type="checkbox"/> 36. I feel that my mouth opening is restricted.
<input type="checkbox"/> 37. I have had swelling.
<input type="checkbox"/> 38. I am swollen.
<input type="checkbox"/> 39. I am presently on antibiotics.
<input type="checkbox"/> 40. I am presently taking pain medication.
<input type="checkbox"/> 41. I had a gum blister or boil.
<input type="checkbox"/> 42. Cold drinks and ice relieves the pain.
<input type="checkbox"/> 43. The tooth feels loose.
<input type="checkbox"/> 44. I have a strange taste in my mouth.
<input type="checkbox"/> 45. Other: _____

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Root canal treatment is an attempt to retain a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally, a tooth which has had root canal therapy, may require retreatment, surgery or even extraction. Existing restoration needs to be replaced after endodontic treatment.

I, hereby, grant authority to the dentist(s) in charge of the care of the patient whose name appears on this form to administer any treatment; or to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible alternative methods of treatment, including no treatment at all.

I have been informed of all possible complications of the procedures, anesthetics and / or drugs and I have been presented with a copy of the Dental Board of California's Dental Materials Fact Sheet. I have been given the opportunity to question the doctor concerning the nature of the treatment, the inherent risks of the treatment, and the alternatives to this treatment. This consent form does not encompass the entire discussion I had with the doctor regarding the proposed treatment. I also understand that all fees for services are to be paid at the time of treatment, and all the records, x-rays, etc. are the property of this office.

SIGNED _____ **DATE** _____

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Relationship to the patient _____ **Reviewed by Dr.** _____ **Date** _____