TOOTH AND PAIN HISTORY

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

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

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** _____

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