MEDICAL HISTORY

1. Are you currently under medical treatment? _____

2. Are you currently taking any medications? _____
Please describe_____

3. Have you had any allergic reactions to any of the following?
Local Anesthetic (epinephrine).....Yes_____ No_____
Latex.....Yes_____ No_____
Penicillin.....Yes_____ No_____
Codeine.....Yes_____ No_____
Other_____

4. (Women Only) are you pregnant? Yes _____ No _____ Nursing? Yes _____No _____

Please circle all that apply:

AIDS	Heart Murmur	High Blood Pressure
Anemia	Heart Problems	Mitral Valve Prolapse
Artificial Heart Valves	Hepatitis/Type___	Rheumatic Fever
Artificial Joints	Herpes	Stroke
Abnormal Bleeding	HIV Positive	

CONSENT

I, the undersigned, consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor.

I understand that the root canal treatment is a procedure to retain a tooth that may otherwise require extraction. There is a high degree of clinical success, however, it is still a biological procedure. The risks involved during the root canal procedure include, but are not limited to, perforation of tooth, separation of instruments in the canals, overfilling and underfilling, breakage of crown. Occasionally, a tooth that has had root canal treatment may require re-treatment, surgery or extraction.

I understand that following the root canal treatment, my tooth will be brittle and must be protected against fracture by placement of a crown/cap over the tooth. This will require that I return to my general dentist's office for this separate procedure.

Signature of Responsible
Party_____Date_____

(Please complete the following page)