Foundation Endodontics / Dr Lewis
870 Palisade Avenue
Suite # 303
Teaneck, NJ 07666
Ph # : 201-836-8000
Fax # : 201-591-7981

Patient Personal Information

Title		Nickname		Birth Date		Age	
Last, First				Marital Status		Sex	
Address				Home #		Work #	
				Cell #		Drive Lic	
City, State, Zip				Emergency Contact		Emergency Phone #	
Email				Student		SSN	
Health Care Guardian Name				School Name			
Health Care Guardian Phone #				Referral Type			

Person responsible/guarantor for paying bills

Title		Nickname		Birth Date		Age	
Last, First				Marital Status		Sex	
Address				Home #		Work #	
				Cell #		Drive Lic	
City, State, Zip				SSN			
Email							

Do you have Primary Dental Insurance? __ Yes __ No				Do you have Secondary Dental Insurance? __ Yes __ No			
Group No/Name				Group No/Name			
Insurance Name				Insurance Name			
Phone #				Phone #			
Employer Name				Employer Name			
Subscriber Last, First				Subscriber Last, First			
Subscriber Address				Subscriber Address			
City, State, Zip				City, State, Zip			
Relationship to Patient		Birth Date		Relationship to Patient		Birth Date	
Subscriber ID				Subscriber ID			

Patient Medical Information

Allergic To/ Adverse reaction

- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Barbiturates
- ☐ Y ☐ N Codeine / Narcotics
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Iodine
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Local Anesthetics/epinephrine
- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N Sulfa Drugs

Check, if applicable

- ☐ Y ☐ N AIDS/HIV Infection
- ☐ Y ☐ N Alcohol/Drug Abuse
- ☐ Y ☐ N Anemia / Leukemia
- ☐ Y ☐ N Arthritis
- ☐ Y ☐ N Asthma / Hay Fever
- ☐ Y ☐ N Blood Clotting Problems
- ☐ Y ☐ N Blood Transfusion
- ☐ Y ☐ N Bronchitis
- ☐ Y ☐ N Cancer / Tumor
- ☐ Y ☐ N Cardiac Pacemaker
- ☐ Y ☐ N Chest Pain On Exertion
- ☐ Y ☐ N Damaged Heart Valve
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Emphysema
- ☐ Y ☐ N Environmental Allergies
- ☐ Y ☐ N Epilepsy
- ☐ Y ☐ N Fainting / Seizures
- ☐ Y ☐ N Fever Blisters / Herpes
- ☐ Y ☐ N Frequent Headaches
- ☐ Y ☐ N Dry Mouth / Sjogren
- ☐ Y ☐ N Heart Attack / Stroke
- ☐ Y ☐ N Heart Disease / Angina
- ☐ Y ☐ N Heart Murmur
- ☐ Y ☐ N Hepatitis / Jaundice
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Joint Replacement
- ☐ Y ☐ N Kidney / Bladder Trouble
- ☐ Y ☐ N Liver Disease
- ☐ Y ☐ N Low Blood Pressure
- ☐ Y ☐ N Mental Health Problems
- ☐ Y ☐ N Mitral Valve Prolapse
- ☐ Y ☐ N Osteoperosis
- ☐ Y ☐ N Persistent Diarrhea
- ☐ Y ☐ N Premedicate
- ☐ Y ☐ N Rheumatic Fever
- ☐ Y ☐ N Rheumatic Heart Disease
- ☐ Y ☐ N Sexually Transmitted Disease
- ☐ Y ☐ N Shortness of Breath
- ☐ Y ☐ N Sinus Trouble
- ☐ Y ☐ N Stomach Ulcers
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N Tuberculosis
- ☐ Y ☐ N Unusual Weight Loss
- ☐ Y ☐ N Urinate Frequently
- ☐ Y ☐ N None of the above apply

Additional Comments

Dental Questionnaire

Review checklist for previous section: (It is critical we get all 6 pieces of information)

Dental Ins. carrier/ ID#/ Group#; Ins. subscriber's name/DOB/ employer have all been filled out. ____________________

If you are having trouble with submitting ins info call 201 836 8000 during business hours

Name of the general dentist who referred you to us. ____________________

How severe is your pain? 0=no pain 10=So bad I can't sleep (if 0 skip the next 4 questions.) ____________________

My tooth pain is triggered or made worse when it is exposed to hot or cold air/drinks. ☐

My tooth pain is triggered or made worse when I chew on or press directly on the tooth. ☐

My pain is triggered when I press on the gum tissue near the tooth. ☐

Has the tooth in question already undergone root canal therapy once before? ☐

If yes was the root canal done recently (within the past 2 years?) ☐

40% of chronic sinus infections originate from a tooth & is easily misdiagnosed

Do you have a history of chronic low grade sinus discomfort or a post nasal drip? ____________________

Fee disclosure:Fee for root canal ranges b/w 1200-1800$ (uninsured)

Dental insurance copayments typically range from $0-600 dependent upon plan coverage

Payment/Copayment is expected day of service. If a payment plan is needed please check the box. ☐

Medical Questionnaire

MEDICAL Questionnaire

If under the care of a medical physician please provide their name and phone number ____________________

List any specific medical conditions you are being treated for. ____________________

If pregnant please list your due date. ____________________

List all medications you are currently taking (including aspirin and birth control) ____________________

Have you ever taken bisphosphonates (a class of bone strengthening medicine) ____________________

Have you had any serious illness, operation or been hospitalized within the past 5 years ? ____________________

By signing below, I certify that all of the above information is true to the best of my knowledge.

____________________	____________________
Patient/Guardian Signature	**Date**

____________________	____________________
Dentist Signature	**Date**