

Welcome to Cala Hills Endodontics

Patient Information

Date _____

Patient Name _____ Spouse _____

Mailing Address _____ City _____ State _____ Zip _____

Sex: Male ___ Female ___ Birthdate _____ Age _____ Patient SS# _____

Occupation _____ Employer _____

Spouse Occupation _____ Employer _____

Whom may we thank for referring you? _____

Who is your General Dentist? _____

Dental Insurance Carrier _____ Subscriber _____

Subscriber Birthdate _____ Subscriber SS# _____

Phone Numbers

Home Phone _____ Work Phone _____

Cell Phone _____

Emer. Contact _____ Phone _____

Dental History

Reason for today's visit? _____

Rate the level of your pain (1-hardly noticeable, 10-worse pain ever experienced) _____

How long have you experienced this pain? _____

Have you had any recent dental treatment? _____ What was done? _____

What have you taken for the pain? _____ Does it help? _____

What is the nature of your pain? (check all that apply):

Dull ache / throb

Pain is sharp

Pain is constant

Pain is intermittent, when does it hurt? _____

Sensitive to air

Sensitive to sweets

Sensitive to cold _____ cold starts throb _____ pain goes away when cold is removed

Sensitive to heat _____ heat starts throb _____ pain goes away when heat is removed

Pain is spontaneous (comes on by itself, does not have to be provoked)

Pain is only when provoked (by hot, cold, chewing, etc).

Pain seems to radiate

Pain keeps me up at night or causes me to wake at night

I have a history of clenching / grinding my teeth

My jaw clicks / pops

I have pain that seems to be localized around my ear