



PLACE D'ORLEANS DENTAL OFFICE

EMERGENCY PATIENT INFORMATION FORM

Existing Patient: **Yes** **No**

Full Name: _____

Address: *(New patients only)* _____

Phone Res.: _____ **Bus.:** _____ **Cell:** _____

Are you in pain/ how long? _____

For office use only:

- 1. We will see you
- 2. Depending on your situation we may not be able to complete the entire TX
- 3. We will help relieve the pain

Describe the pain:

Throbbing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sensitive to hot/cold	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sensitive to pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other: _____		

Where is the pain? *(Circle the appropriate areas)*

Upper Lower Right Left Front Back

Is there any swelling? **Yes** **No**

Have you had dental work done on this tooth before? **Yes** **No**

Allergies to medication? **Yes** **No**

Which ones? _____

Do you require premedication? **Yes** **No**

Antibiotics prior to dental treatment? **Yes** **No**

Are there any medical/health conditions that we should be aware of?

(New patients only)

Special Notes: _____

E-Mail Address: _____