PATIENT INFORMATION AND DENTAL HISTORY

Patient's Name_____ Date of Birth_____

Home Address _____ Home Phone _____

City_____ State_____ Zip Code_____

Driver's License #_____ Referred by_____

Employed by_____ Business Phone_____

Social Security_____ Cell Phone_____

May we send text messages to your cell number? ☐ No ☐ Yes

Email address_____

Spouse's Name_____

Employed by_____Business Phone_____

Who is responsible for this account?_____

INSURANCE

Dental Plan _____ Group/Policy #_____

Insured ☐ Self ☐ Spouse ☐ Parent ☐ Other

D.O.B. of Ins._____SS # of Ins._____

ENDODONTIC HISTORY

To assist us in understanding and diagnosing your dental condition, please answer the following questions.

PRESENT DENTAL ILLNESS

1. What is your problem?_____
2. How long has this tooth been bothering you?_____
3. How and when did accident occur?_____

_____

4. Have you taken any pain medications today?_____

DESCRIPTION OF DENTAL PAIN

	Yes	No
1. Is pain constant?	☐	☐
2. Does pain come and go?	☐	☐
3. Is ache a dull throb?	☐	☐
4. Is ache a sharp piercing pain?	☐	☐
5. Is tooth sore to touch.bite?	☐	☐
6. Does tooth awaken you at night?	☐	☐
7. Do you have pain in your ear?	☐	☐
8. Did your DDS tell you that you needed a root canal?	☐	☐
9. Do hot foods/fluids cause pain?	☐	☐
10. Do cold foods/fluids cause pain?	☐	☐
11. Do sweets cause pain?	☐	☐
12. Does cold relieve pain?	☐	☐
13. Are your gums sore?	☐	☐
14. Does tooth feel loose, too long or out of its socket?	☐	☐
15. Does change of altitude cause pain?	☐	☐

Please provide us with any other information you feel is important_____

_____

_____

(OVER)

MEDICAL HEALTH HISTORY

THANK YOU for taking the time to provide us with the *essential* information. It will be used to select the safest and most effective means of treating you. Of course, all information on this form is completely confidential.

1. Please describe your present health: Excellent ☐ Good ☐ Fair ☐ Poor ☐
2. Has your present health CHANGED in the last year?..... Yes ☐ No ☐
3. Have you been HOSPITALIZED for illness or surgery?..... Yes ☐ No ☐
4. The name of my PHYSICIAN is_____
5. Are you ALLERGIC to any drugs or other substances?..... Yes ☐ No ☐
   if so, to what?_____
6. Have you ever experienced BLEEDING that was difficult to stop?.. Yes ☐ No ☐
7. Are you taking any medications?(including baby aspirin or vitamins)Yes ☐ No ☐
   if so, please list them:_____

_____

PLEASE INDICATE YES OR NO FOR ANY CONDITION EVEN IF YOU NO LONGER HAVE THEM.

	Yes	No		Yes	No		Yes	No
Heart Trouble	☐	☐	Hepatitis	☐	☐	Tumors / Growths	☐	☐
Heart Murmur	☐	☐	Immune System Problems	☐	☐	Infections	☐	☐
Heart Surgery	☐	☐	Jaundice	☐	☐	Emotional Problems or Tension	☐	☐
Rheumatic Fever	☐	☐	Diabetes	☐	☐	Often Thirsty	☐	☐
Congenital Heart Lesions/Defects	☐	☐	Kidney Disease	☐	☐	Frequent Urination	☐	☐
Heart Pacemaker	☐	☐	Liver Disease	☐	☐	Often Fatigued or Exhausted	☐	☐
Heart Valve Prosthesis	☐	☐	Persistent Cough	☐	☐	Frequent Headaches	☐	☐
Heart Attack	☐	☐	Asthma	☐	☐	Heavy Smoker	☐	☐
High Blood Pressure	☐	☐	Lung Disease	☐	☐	Nervous/Anxious	☐	☐
Low Blood Pressure	☐	☐	Tuberculosis	☐	☐	Depressed/Unhappy	☐	☐
Ankles Swell	☐	☐	Bronchitis	☐	☐	Any recent unintentional Weight Changes	☐	☐
Hardening of Arteries	☐	☐	Frequent Colds/ Sore Throats	☐	☐	Sinus Trouble	☐	☐
Shortness of Breath on Mild Exertion	☐	☐	Emphysema	☐	☐	Artificial Joints	☐	☐
Chest Pains on Mild Exertion	☐	☐	Epilepsy	☐	☐	Swollen Lymph Glands	☐	☐
Scarlet Fever	☐	☐	Fainting	☐	☐	Psychiatric Care	☐	☐
Hives / Rash	☐	☐	Ulcers	☐	☐	Venereal Disease	☐	☐
Hay Fever	☐	☐	Stroke	☐	☐	Thyroid / Parathyroid Disorders	☐	☐
Recurrent Illness	☐	☐	Arthritis	☐	☐	Cancer Treatment	☐	☐
			Anemia / Blood Disease	☐	☐	Are You Pregnant?	☐	☐
			Glaucoma	☐	☐			

IS THERE ANY CONDITION OR PROBLEM THAT YOU THINK WE SHOULD KNOW ABOUT?

I authorize the dentists to release any information about diagnosis or records to other health care practitioners or third party payers, and I hereby authorize benefits to be paid directly to Endodontic Specialty Services, L.L.C.

_____ Date: _____

Patient's Signature

(Or Parent or Guardian if Patient is a Minor)

Reviewed By: _____

ENDODONTIC SPECIALTY SERVICES

ENDODONTIC CONSENT AND INFORMATION FORM

Welcome to our office. Before we begin your treatment, we'd like you to know as much as possible about the risks which endodontic (root canal) therapy may pose and possible alternatives to endodontic treatment. This information is not intended to alarm you. It is a means by which we determine that you have read, understood and consented to the procedures involved in endodontic therapy. We have been advised not to begin treatment on anyone who has not read and signed this form.

GENERAL RISKS OF DENTAL PROCEDURES: Include (but are not limited to) complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections. These complications may include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth; thrombophlebitis (inflammation to a vein); reaction to injections; change in occlusion (biting); muscle cramps and spasms; temporomandibular (jaw) joint difficulty; loosening of teeth or restorations in teeth; injury to other tissues; referred pain to the ear, neck and head; nausea; vomiting; allergic reactions; itching; bruises; delayed healing; sinus complications; and further surgery.

MEDICATIONS: Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be intensified by the use of alcohol, tranquilizers, sedatives or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from the effects of the medications and drugs.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY: The risks include the possibility of instruments broken within the root canals; perforations (extra openings) of the crown or root of the tooth; damage to bridges, existing fillings, crowns or porcelain veneers, loss of tooth structure in gaining access to canals, and cracked teeth. During treatment, complications may be discovered which make endodontic treatment impossible or which may require dental surgery. These complications may include blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum) disease, and splits or fractures of the teeth.

OTHER TREATMENT CHOICES: These include no treatment, waiting for more definite symptoms to develop, tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infection to other areas.

Root canal treatment is an attempt to retain a tooth which may otherwise require extraction. Although the endodontic treatment performed will be effectuated in a manner which will minimize and avoid risks and has a very high degree of clinical success, it is still a biological procedure and cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery, or even extraction.

I have carefully read the above statements about endodontic therapy, my questions have been answered to my satisfaction, and I give my consent to the procedure. I realize that I can obtain a copy of this form upon request. I also understand that upon completion of my root canal therapy in this office, I will be instructed to return to my general dentist for a permanent restoration of the tooth. I realize that a check up x-ray should be taken in 6 months by my general dentist or by the treating endodontist.

CONSENT: I, the undersigned patient (parent or guardian of the minor patient), consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. In consideration of the services rendered, I as the patient or responsibility party, obligate myself to pay the account. Should my account be referred for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

SIGNATURE OF PATIENT OR GUARDIAN _____ DATE _____

SIGNATURE OF WITNESS _____ DATE _____

PRIVACY NOTICE ACKNOWLEDGEMENT

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I chose) and understand the Notice.

_____ _____

Patient Signature Date

_____

Print Patient Name

_____

Parent or Authorized Representative (if applicable)

PAYMENT OPTIONS

If your treatment takes one visit, you must pay the total cost of the procedure at that visit.

If your treatment requires two visits you may pay approximately 50% down at your first visit and pay the remaining balance at the last treatment.

Cash, American Express, Master Card, Visa and Discover charge cards are accepted for payment on your account. Personal checks are accepted with proper identification.

INSURANCE

For your convenience, we will prepare and send your insurance claims for you. If you are covered by an insurance company that we are contracted with, we will accept the insurance payment and apply it towards your account, however we will require payment of your ESTIMATED amount owed, at time of service.

I UNDERSTAND THAT THE INSURANCE "ESTIMATE OF BENEFITS" FOR MY TREATMENT RECEIVED AT ENDODONTIC SPECIALTY SERVICES, LLC IS NOT A GUARANTEE OF BENEFITS, AND I ACCEPT RESPONSIBILITY FOR ANY UNPAID ACCOUNT BALANCE THAT MAY BE DUE AFTER MY INSURANCE PAYMENT IS RECEIVED. UNPAID BALANCES WILL BE TURNED OVER TO A COLLECTION AGENCY AND REPORTED TO THE CREDIT BUREAU.

_____ _____

Patient or Authorized Representative Date