Patient Record/Medical History

Name: _____ Birthdate: _____
First Middle Initial Last

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Patient's Social Security Number: _____ Responsible Party S.S. Number: _____

Mailing Address _____ Street Address (No P.O. Box) _____

City _____ State _____ Zip Code _____

Have you ever been a patient here before? ❑ Yes ❑ No Year _____ Employed by: _____

Referred by _____ City _____

In order to render thorough care and to avoid unnecessary complications, the doctor needs the answers to the following questions to "screen" your general health. Please check the appropriate box for each question.
Have you ever had, or been told you have:

Yes	No		Yes	No	
❑	❑	Heart Disease	❑	❑	Arthritis
❑	❑	Heart Defect or Murmur	❑	❑	Asthma
❑	❑	Mitro Valve Prolapse	❑	❑	Bronchitis
❑	❑	Artificial Heart Valves	❑	❑	Lung Disease
❑	❑	Artificial Joints (Hip, Hand)	❑	❑	Liver Disease
❑	❑	High or Low Blood Pressure	❑	❑	Kidney Disease
❑	❑	Bleeding Problems	❑	❑	Diabetes
❑	❑	Rheumatic Fever	❑	❑	Epilepsy
❑	❑	Blood Transfusion - What Year	❑	❑	Fainting
❑	❑	Injury to Face, Jaws, or Teeth	❑	❑	Cancer
❑	❑	Mental or Emotional Disorders	❑	❑	Tumor (Malignant or Benign)
❑	❑	Drug or Alcohol Addiction	❑	❑	Ulcer
❑	❑	Cortisone Steroid Treatment	❑	❑	Hepatitis
❑	❑	Radiation Treatment	❑	❑	AIDS (Acquired Immune Deficiency Syndrome)
❑	❑	Chemotherapy	❑	❑	ARC (AIDS Related Complex)
❑	❑	Sinus Problems	❑	❑	Hiv + (Human Immuno Virus Positive)

Are you in good health now? ❑ Yes ❑ No
Have you ever been told to premedicate with antibiotics for a **medical condition** before dental visits? ❑ Yes ❑ No
Are you under a physician's care for any reason now? ❑ Yes ❑ No
Have you ever been hospitalized in the past two years? ❑ Yes ❑ No Why? _____
Have you ever taken medication containing bisphosphonates? ❑ Yes ❑ No Why? _____
Are you taking any medication now? ❑ Yes ❑ No If yes, list: _____
What medication have you taken in the last five days? _____
Women: Are you pregnant? ❑ Yes ❑ No ❑ Unsure How many months? ____ Are you breastfeeding? ❑ Yes ❑ No

Are you allergic to or have you ever had hives or itching from: (Check only if answer is YES)

❑ Penicillin ❑ Local Anesthetics (Novocaine, etc.) ❑ Percodan ❑ Aspirin ❑ Cipro (Please list others):
❑ Erythromycin ❑ Keflex ❑ Lortab ❑ Tylenol ❑ Ampicillin _____
❑ Tetracycline ❑ Ceclor ❑ Codeine ❑ Demerol ❑ Other _____

Do you have any other medical condition, disease, or ailment not covered by the above? ❑ Yes ❑ No If yes, please list:

_____

Please sign: _____ Date: _____

— Please read other side —

Please read: This contains important information concerning your treatment and will answer many of your questions.

Endodontic (Root Canal) Informed Consent

1. The purpose of root canal therapy is to retain teeth that would otherwise have to be extracted.

2. Treatment averages between 1 - 2 visits. Most visits last 2 to 3 hours. It is important that you maintain regular appointments or the infection can reoccur.

3. In most cases, mild discomfort following each treatment can usually be controlled with aspirin, Tylenol, or prescribed medication. Antibiotics may decrease the effectiveness of oral contraceptives; please consult your physician.

4. Successful treatment occurs in about 80 to 90% of cases. This treatment, as with any medical or dental treatment, has no guarantee of success for any length of time. Teeth with previous root canal treatment will have more complications and therefore a higher failure rate. For your safety, we require protective eyewear; and that your shoes be kept on at all times!

5. Accurate and complete disclosure of your medical history is necessary for proper diagnosis, and to help prevent unnecessary complications during your treatment.

6. If you have artificial joints or damaged heart valves, premedication with antibiotics may be necessary for a dental exam.

7. The most common complications with root canal therapy include, but are not limited to:
   A. Continued infection requiring endodontic (root canal) surgery or extraction of the tooth.
   B. Calcified canals or canals blocked by fractured instruments requiring endodontic (root canal) surgery or extraction of the tooth.
   C. Side effects and reactions to the medication including, but not limited to: itching, rash, upset stomach, and difficulty in breathing (allergic reaction). Temporary or permanent numbness may occur in **extremely rare** circumstances.
   D. Fractures (breaking) of the root or crown of the tooth during or after treatment. It is recommended that all posterior teeth be crowned following root canal treatment. If your tooth already has a crown, there is about a 5% chance it will need to be replaced due to decay or loss of structural support. Porcelain crowns are subject to breakage.
   E. Tenderness of the tooth following treatment due to possible complications with root canal treatment, gum disease, or physical stress from chewing.
   F. Chemicals may be used during treatment. They may cause irritation, or a reaction.

8. Radiographs (X-rays) will be taken during the course of treatment. Photographs of your teeth may also be taken.

9. The Endodontist's fee includes only endodontic (root canal) treatment. It does **NOT** include endodontic (root canal) surgery, post and core buildup, or permanent filling or crown. A durable temporary will be placed following each visit to keep food and saliva out of your tooth. Fees will be quoted before treatment and will remain unchanged unless Endodontic (root canal) surgery becomes necessary.

10. About Insurance... Please do not assume that all or part of the root canal fee will be paid by your insurance. Insurance companies vary widely in their coverage. Please check with your insurance company if you are unsure. We will be glad to file your insurance for you. However, any portion that the insurance does not cover is expected when treatment is started. Over payment refunds take a minimum of 4 weeks. If treatment is not complete within 120 days, your insurance will be filed. If your claim involves medical insurance for documented accidents, we will provide you with the necessary papers for you to file claim.

11. Payment in full is expected when service is rendered unless other arrangements are made in advance. A monthly service charge of 1.5% and billing fee will be added to accounts more than 30 days old following completion of treatment. If, in the event the account is not paid when due, and services are needed for collection of this debt, the patient and responsible parties shall pay all costs and expenses of collection of the account including reasonable attorney fees or clerical fees incurred by this office. Service charges will be applied to returned checks.

12. Root canal therapy is slow and tedious work – delays may occur. The office handles complicated and numerous emergencies many times a day. We apologize for the delays. If you are an emergency or work-in patient, **this is not a regular appointment time.** If you did not speak directly with this office you may not have been informed of possible delays. Please check with the receptionist about delays.

13. The doctor will discuss your treatment with you. If you have any questions, please ask. Signing this does not obligate you to start any procedure. As a patient, you may discontinue treatment at any time. Fees will be prorated for the portion of your treatment completed.

We will be glad to provide you with a copy of this form. Thank you for choosing our office for your endodontic care.

I have read and understand the above.

Please sign: _____ Date: _____

Patient and Responsible Party Signature