MEDICAL HISTORY

Circle One: Mr. Ms. Mrs. Dr. Sr. Hon. Rev. Date _____

Patient _____
Last Name First Name Initial

Medical Doctor's Name _____ Date of Last Physical _____

Have you ever had any of the following? (check boxes that apply):

- ☐ Artificial Joints
- ☐ Mitral Valve Prolapse
- ☐ Heart Murmur
- ☐ Rheumatic Fever
- ☐ Artificial Heart Valves

If yes to any of the above, is antibiotic premedication required? ☐ Yes ☐ No _____ Initial

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Attack
  When?_____
- ☐ Respiratory Disease
- ☐ Turberculosis
- ☐ Hearing Impaired
- ☐ Vision Impaired
- ☐ Asthma
- ☐ Circulatory Problems
- ☐ Hemophilia or Bleeding Disorders
- ☐ Stroke
- ☐ Hepatitis or Liver Disease
- ☐ Cancer
  If yes, what type?_____
  When was diagnosis?_____
- ☐ Chemotherapy
- ☐ Radiation
- ☐ Diabetes
  Type 1 ☐ or Type 2 ☐
- ☐ Epilepsy
- ☐ Seizures
- ☐ Thyroid Disease
- ☐ HIV or AIDS
- ☐ Frequent Headaches
- ☐ Sinus Problems or Allergies
- ☐ Arthritis
- ☐ Back Problems
- ☐ Stomach Ulcers
- ☐ Cold Sores
- ☐ Mental Handicap
- ☐ Severe Anxiety
- ☐ Psychiatric Care
- ☐ Recovering Chemical Dependence
- ☐ Nervous Problems
- ☐ Allergy to Latex
- ☐ Allergies to Anesthetics
- ☐ Allergies to Drugs (list below)

Please list medication allergies and/or any adverse reactions you have had to medical or dental treatment.

_____

Are you taking any medication at this time? ☐ Yes ☐ No If so, what _____

_____

Are you under the care of a physician? ☐ Yes ☐ No For what condition?_____

(women) Do you suspect that you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____

Emergency contact name: _____ Phone:_____

Patient (or Guardian) Driver's License No.: _____

FINANCIAL AGREEMENT

(Please initial A or B as applicable and sign below)

A With Dental Insurance

If you have dental insurance we will gladly file it for you. We request that you pay your "patient portion" today, on the day of treatment, which is the estimated amount your insurance will not cover. We will verify your benefits and inform you of this amount on the day of your appointment or you may call your insurance company for this information. Once insurance pays, we will send you a statement or refund to reconcile your account.

I have insurance and will pay my estimated "patient portion" by cash, check or credit card today. _____

B Without Dental Insurance

I do not have dental insurance and will pay in full today. _____

If payment arrangements are needed, please discuss this with our front office PRIOR to treatment

We accept cash, check, Visa, MC, Discover and American Express - CareCredit & Citihealth (6 mos/no interest plans by application.) We will apply a 5% discount for cash payment in full (applies only for "real cash").

I have read and understand the above. I agree to the payment option I have selected and agree to pay any and all collection, attorney fees, court cost, interest fees (1.5% per month (18% annual) after 60 days) and/or any other additional fees should my account be turned over to any attorney or collection agency. I understand I am paying an "ESTIMATED" amount and I am responsible for any remaining balance after insurance pays. I realize that I am also responsible for a $20 service charge for any returned check.

_____ _____

Patient/Responsible Party Signature Date

INFORMED CONSENT for ENDODONTIC TREATMENT

The Medical Consent Law requires doctors to advise patients of the general nature of treatment procedures, the acceptable treatment alternatives, and the risks inherent in the proposed procedures.

I voluntarily consent to endodontic (root canal) treatment that has been recommended. I understand that the goal of root canal treatment is to save a tooth that might otherwise require extraction. Although root canal treatment has a very high success rate, it is a dental-biological procedure, whose results cannot be guaranteed. Further, root canal treatment is performed to correct an apparent problem and occasionally undiagnosed or hidden problems arise. I understand that this procedure will not prevent future tooth decay or a possible fracture, and that occasionally a tooth that had root canal treatment may require re-treatment, surgery or tooth extraction.

The treatment has been fully explained to me including the risks involved. I have been informed that complications might include, but are not limited to:

a) Perforation of the canal with instruments, which could result in the need for root canal surgery or the loss of the tooth.

b) Instrument breakage in the canal, which may require re-treatment, root canal surgery or extraction.

c) Incomplete healing, which may require re-treatment and/or root canal surgery or extraction.

d) Post-operative infection, which may require additional treatment and/or the use of antibiotics.

e) Tooth fracture, that may require additional treatment or tooth extraction.

f) Referral to a specialist if any unexpected difficulties occur during treatment.

g) Post-treatment discomfort, altered feeling of the soft-tissues of the mouth.

I am aware that the condition of the tooth will worsen and that other systemic (medical) problems could possibly develop if the recommended procedure is not done. It has been explained that other treatment options might be possible, such as, tooth extraction, and followed by fixed or removable bridge-work, or placement of dental implants.

After the completion of the root canal procedure, you will be referred back to your restorative dentist for the permanent restoration (filling, crown, onlay). Failure to have the tooth properly restored significantly increases the possibility of re-infection, failure of the root canal procedure and/or tooth fracture.

Our office participates in research and teaching. We routinely tape our endodontic procedures through the microscope. Occasionally we use excerpts from this video footage along with radiographs in our lectures. If you would prefer to not participate in this program please check here. ☐

I realize that I will have an opportunity to ask questions of my doctor prior to treatment.

Patient/Guardian:_____ **Date:**_____

Witness:_____ **Tooth #:**_____