PATIENT INFORMATION

Name: _____ E-mail Address: _____

Address: _____
Street City State Zip Code

Birthdate: ____/____/____ SS # ____-____-____ Please Circle: Single / Married / Widowed / Divorced

Home Phone (____)____-____ Work (____)____-____ Cell (____)____-____

Occupation: _____ Employer: _____

Spouse's Name: _____ Work Phone: (____)____-____

Emergency Contact: _____ Relationship: _____ Phone: (____)____-____

Whom may we thank for referring you? _____

HEALTH HISTORY

Physician's Name _____ **Date of last visit:** _____

Address: _____ **Phone:** _____

Please mark "Yes" or "No" to indicate if you have ever had any of the following:

Cardiovascular

Angina	☐ Yes	☐ No
Arteriosclerosis	☐ Yes	☐ No
Atrial Fibrillation	☐ Yes	☐ No
Circulation Problems	☐ Yes	☐ No
Heart Attack Date: _____	☐ Yes	☐ No
Heart Defect	☐ Yes	☐ No
Heart Murmur / Leaky Valve	☐ Yes	☐ No
High or Low Blood Pressure	☐ Yes	☐ No
Mitral Valve Prolapse / MVP	☐ Yes	☐ No
Pacemaker / Defibrillator	☐ Yes	☐ No
Rheumatic or Scarlet Fever	☐ Yes	☐ No
Stroke Date: _____	☐ Yes	☐ No
Swelling of Feet or Ankles	☐ Yes	☐ No
Valve Replacement	☐ Yes	☐ No

Circulatory / Hematological

Abnormal Bleeding	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Leukemia / Lymphoma	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No

Neurological

Dizziness, Fainting	☐ Yes	☐ No
Epilepsy / Seizure	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Vision / Hearing Impairment	☐ Yes	☐ No

Respiratory

Asthma	☐ Yes	☐ No
Cough, persistent or bloody	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Psychiatric Care	☐ Yes	☐ No
Shortness of breath	☐ Yes	☐ No
Sinus Infection	☐ Yes	☐ No

Infectious Diseases

HIV / AIDS	☐ Yes	☐ No
Swollen Glands -neck	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Herpes	☐ Yes	☐ No

Endocrinological

Diabetes Type: _____	☐ Yes	☐ No
Thyroid: _____	☐ Yes	☐ No

Musculoskeletal

Arthritis / Rheumatism	☐ Yes	☐ No
Cortisone / Steroid Treatment	☐ Yes	☐ No
Joint Replacement (knee, hip, etc.)	☐ Yes	☐ No

Gastrointestinal

Diarrhea, persistent	☐ Yes	☐ No
Digestive Disorder	☐ Yes	☐ No
Hiatal Hernia	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No
Hepatitis, Type: _____	☐ Yes	☐ No
Ulcer / Hyperacidity	☐ Yes	☐ No

Other

Autoimmune /Immune Problem	☐ Yes	☐ No
Cancer Type: _____	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Weight Loss, Unexplained	☐ Yes	☐ No
Birth Control Pills: _____	☐ Yes	☐ No
Nursing?	☐ Yes	☐ No
Pregnant Due: _____	☐ Yes	☐ No

Please list any other medical concerns/conditions we should know about: _____

Have you ever been told you need to premedicate or take antibiotics prior to a dental procedure? Y / N Condition: _____

MEDICATIONS

List all medications you are currently taking:

ALLERGIES

Circle Yes or No

Aspirin	Yes	No
Codeine/Other Narcotics	Yes	No
Iodine	Yes	No
Latex	Yes	No
Penicillin	Yes	No
Sulfa	Yes	No
Other Antibiotics _____	Yes	No

Other: _____

SURGERY

List ALL past surgery, major and minor please:

Tobacco Use: (circle all that apply)

Cigarettes Cigars Pipe Chew/Dip

How often?

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____
Signature of Patient Date

RESPONSIBLE PARTY INFORMATION

Responsible Party: _____ Relationship to Patient: _____

Address: _____

Phone: ( ) - _____ Birthdate: / /

_____ _____

Signature of Responsible Party Date

DENTAL INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient: _____

Insured's Birthdate: / / SSN #: - - Work Phone: ( ) -

Employer: _____

Name Address

Insurance Company: _____ Group # _____ ID # _____

Ins. Co. Address: _____

City State Zip Code

Do you have additional insurance? Yes / No If yes, please complete the following:

Name of Insured: _____ Relationship to Patient: _____

Insured's Birthdate: / / SSN #: - - Work Phone: ( ) -

Employer: _____

Name Address

Insurance Company: _____ Group # _____ ID # _____

Ins. Co. Address: _____

City State Zip Code

ASSIGNMENT and RELEASE

I, the undersigned, certify that I have insurance coverage as stated above, and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Responsible Party Signature Date

HIPPA Privacy Rule

Receipt of Notice of Privacy Practices

Written Acknowledgement Form (164.520 a)

I, (Please Print Name)_____understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I acknowledge that I have been provided with and understand this facility's **Notice of Privacy Practices** provides a complete description of these uses and disclosures of my health information.

I understand that:

* I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement.
* This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided, if requested.

I grant the following individual(s) the authority to access my dental record:_____

_____ _____

Patient or Guardian Signature Date

_____

Print Name

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

____Refusal to sign

____Emergency situation preventing obtaining acknowledgement

____Other (please specify)_____

Endodontic (Root Canal) Informed Consent

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

2. Endodontic treatment has a high percentage of success. As any medical or dental treatment, however, this treatment has no guarantee of success for any length of time. Teeth with previous root canal treatment will have a lower success rate.

3. Treatment occasionally requires multiple visits.

4. In most cases, minor discomfort may follow each treatment. This is usually controlled with Tylenol, Ibuprofen, aspirin, or prescribed medication.

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

6. The most common complications with root canal therapy include, but are not limited to the following:

   *continued infection requiring endodontic (Root Canal) surgery or tooth extraction

   *breakage of an endodontic instrument requiring root canal surgery, extraction, or follow up of the healing process

   *pain; requiring the use medication

   *fractures 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 a chance it will need to be replaced due to decay or loss of structural support. Porcelain crowns are subject to breakage.

   *tenderness of the tooth following treatment due to possible complications with root canal treatment, gum disease, physical stress from chewing, or the degree of healing your body exhibits.

7. Other treatment choices include the following: no treatment, waiting for more definite development of symptoms, and tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infection to other areas.

8. Only the root canal treatment is performed by the endodontist. Your general dentist will place the final restoration (filling, crown, etc.).

Please feel free to ask any questions.

_____ _____

Patient or Guardian Signature Date