

MEDICAL HISTORY

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

Patient _____
Last Name First Name Initial

Physician's Name _____ Date of Last Physical _____

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hemophilia or Bleeding Disorders | <input type="checkbox"/> Sinus Problems or Allergies |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Hepatitis or Liver Disease | <input type="checkbox"/> Back Problems |
| If yes to any of the above, | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stomach Ulcers |
| is antibiotic premedication | If yes, what type? _____ | <input type="checkbox"/> Cold Sores |
| required? <input type="checkbox"/> Yes <input type="checkbox"/> No | When was diagnosis? _____ | <input type="checkbox"/> Mental Handicap |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Severe Anxiety |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Radiation | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Recovering Chemical Dependence |
| When? _____ | Type 1 <input type="checkbox"/> or Type 2 <input type="checkbox"/> | <input type="checkbox"/> Nervous Problems |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Allergy to Latex |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Allergies to Anesthetics |
| <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Allergies to Drugs (list below) |
| <input type="checkbox"/> Vision Impaired | | |

If you have ever had an adverse reaction to any medication please list here.

Have you ever responded adversely 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: _____

FINANCIAL AGREEMENT

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

A With Dental Insurance - please read and check the following options:

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 - please read and check the following options:

I do not have dental insurance and will pay by:

- _____ Cash payment in full on the day of treatment - receive a 5% discount
- _____ CareCredit Interest free plan for 3 months (high approval rating)
- _____ Citihealth Interest free plan for 3 months
- Please ask for an application if you are interested
- _____ 50/50 plan: pay 50% today by cash, check or credit card
- pay 50% next month with a post dated check or credit card
- _____ Other: pay by check or credit card as arranged with front office

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

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 #: _____