TELL US ABOUT YOUR HEALTH

First Name _____ Last Name _____

How would you describe your health? Please check one. ☐ Excellent ☐ Good ☐ Fair ☐ Poor

When did you have your last physical examination? _____

Are you currently being treated for any illness or medical condition? .....Yes ☐ No ☐

If yes, please describe _____

_____

Who is treating you for this condition? _____

Have you ever had any kind of surgery? .....Yes ☐ No ☐

What type of surgery did you have? _____

When did you have this surgery? _____

Have you ever had any trouble with prolonged bleeding after surgery? Yes ☐ No ☐
Do you wear a pacemaker or any other kind of prosthetic device? Yes ☐ No ☐
Have you ever taken Fen-Phen, Redux or any other diet drugs? Yes ☐ No ☐
Are you taking any medications, drugs or herbs at this time? Yes ☐ No ☐
If yes, list the medications, drugs or herbs you are taking

_____

Why are you taking these medications, drugs or herbs? _____

_____

Have you ever had an unusual reaction to an anesthetic or do you have any drug allergies? _____

If yes, please explain _____

Are you allergic to Latex? ..... Yes ☐ No ☐

Please check any present or past illness you have or have had:

☐Alcoholism	☐Cancer	☐Head/Neck Injuries	☐Infectious Diseases	☐Respiratory
☐Allergies	☐Diabetes	☐Heart Disease	☐Kidney	☐Rheumatic Fever
☐Anemia	☐Drug Dependency	☐Hepatitis	☐Liver	☐Sinusitis
☐Asthma	☐Epilepsy	☐Herpes	☐Mental	☐Ulcers
☐Blood Pressure	☐Glaucoma	☐Immunodeficiency	☐Migraine	☐Venereal Disease

If female, are you pregnant? .....Yes ☐ No ☐

Is there any other information that we should know about your health?

_____

Signature of Patient (or Parent) _____ Date _____

TELL US ABOUT YOUR DENTAL SYMPTOMS

First Name _____ Last Name _____

1. Are you experiencing any pain at this time? If not, please go to Question 5. .....Yes ☐ No ☐
2. If yes, can you locate the pain? .....Yes ☐ No ☐
3. When did you first notice the symptoms? _____
4. Did symptoms occur suddenly or gradually? _____

Please check the word or words below that best describe your pain today**:**

LEVEL OF INTENSITY OF PAIN TODAY

1 = Mild, 10 = Severe
Please check a Number
1☐ 2☐3☐4☐5☐6☐7☐8☐9☐10

FREQUENCY OF PAIN

☐ Constant
☐ Intermittent
☐ Momentary
☐ Occasional

QUALITY OF PAIN

☐ Sharp
☐ Dull
☐ Throbbing
☐ Steady

Is there anything you can do to relieve the pain? .....Yes ☐ No ☐
If yes, what? _____
Is there anything you do that causes the pain to increase? .....Yes ☐ No ☐
If yes, what? _____
When eating or drinking, is your tooth sensitive to: .....Heat ☐ Cold ☐ Sweets ☐
Does your tooth hurt when you bite down or chew? .....Yes ☐ No ☐
Does it hurt if you press the gum tissue around this tooth? .....Yes ☐ No ☐
Does a change in posture (lying down or bending over) cause your tooth to hurt? .....Yes ☐ No ☐

5. Do you grind or clench your teeth? .....Yes ☐ No ☐
6. If yes, do you wear a night guard? .....Yes ☐ No ☐
7. Has a restoration (filling or crown) been placed on this tooth recently? .....Yes ☐ No ☐
8. Prior to this appointment, has root canal therapy been started on this tooth? .....Yes ☐ No ☐
9. Is there anything else we should know about your teeth, gums or sinuses that would assist us in our diagnosis? _____

Signature of Patient (or Parent) _____ Date _____

INFORMED CONSENT

We are concerned not only about your dental health and endodontic treatment needs, but also about your right as a patient to make the treatment decision that you feel is best for you. Our commitment to you is to provide you with detailed and reasonably complete information about your dental needs which we diagnose. We will share our diagnostic findings or opinions with you. We welcome all of your questions regarding our proposed treatment and/or as treatment progresses.

Towards this aim of a mutual sharing of information we feel it is important to advise you of the reasonably foreseeable risks of endodontic therapy. The following is important information you should consider in making your decision about treatment:

- Root canal therapy is a procedure designed to retain a tooth which may otherwise require extraction. Root canal therapy has a very high degree of success greater than 90%. However, as it is a biological procedure, results are not guaranteed.

- Occasionally, and despite our best efforts, a tooth that has undergone non-surgical root canal therapy may require re-treatment or root canal surgery in 5% or less of our patients.

- We make special efforts to preserve the crowns of teeth we treat, but despite our best efforts occasionally a porcelain crown may fracture necessitating a new crown.

- Even after root canal therapy, approximately 5% of endodontically treated teeth may eventually require extraction.

- Final restoration (crown) of the tooth that has undergone root canal therapy is essential for retention of the tooth. A final restoration by your general dentist should be completed as soon as possible, because delay may cause a tooth fracture.

- If you have any unexpected or uncomfortable side effects from prescribed or recommended medications, Dr. Cohen should be notified so he may advise you.

_____ _____

Signature of Patient (or Parent) Date

Notice of Privacy Policy and Patient Acknowledgment

We are committed to providing you with quality care, including protecting the confidentiality of your personal, medical and treatment information. In response to that commitment and in accordance with new federal legislation, we would like to provide you with written notification regarding our office privacy policy and the necessary uses and disclosures of your information.

- We may use your information to provide you with treatment. In treating you for a specific condition, we may need to know if you have allergies or are taking any medication that could affect your treatment in our office, or could interfere with medications we may prescribe.

- We may use your information to provide you with quality care. We may need to review your treatment plan with authorized staff and provide information to other healthcare offices to ensure excellent communication with all of those involved in caring for you.

- We may use your information so that payment for treatment can be processed. Personal information, office visit dates, codes identifying treatment and diagnosis are required for accurate documentation and processing financial information for payment by you or your insurance company.

We may contact you to provide appointment reminders, information regarding your treatment, and to discuss financial information.

We will not, unless required by law, share your protected information with any other agencies without your written authorization.

Patient Acknowledgment
In accordance with federal legislation, I have read and received notice of this privacy policy and understand I do not have to give written permission for these uses of my protected information. I have the right to inspect and copy protected information, to receive confidential communications regarding protected information, to complain if I believe my privacy rights have been violated and to receive a copy of this Notice of Privacy Policy upon request.

_____ _____

Signature of Patient (or parent) Date

INSURANCE/FINANCIAL SUMMARY

Patient Name _____

Primary Dental Insurance*

Name of Insured Person _____ Date of Birth _____

Relationship to Patient Self _____ Spouse _____ Domestic Partner _____ Parent _____

Social Security No. (_____)-(_____)-(_____) Group No. _____

Name of Employer _____

Name of Insurance Company _____

Insurance Company Address _____

Insurance Company Telephone Number _____

Plan Maximum _____ Amount of Deductible _____ Met Yes ___ No ___

FOR OFFICE USE ONLY:

Benefits Currently Available _____ Pending _____

Coverage Diagnostic _____ Basic _____ Major _____ Endodontic _____

Insurance Representative _____ Date _____

Plan Particulars _____

*Please let us know if you have more than one dental insurance carrier.

FINANCIAL AGREEMENT:

While we try our best to accurately estimate your insurance benefits and co-payment, we cannot guarantee the final payment amounts, because they are determined by your insurance company. We collect your estimated co-payment at the time of our service and then as a courtesy for you, bill your insurance company. Your insurance company may take up to 4 weeks to process payment and any portion not paid by your insurance after 4 weeks will become your responsibility, and payable within 30 days. Please sign below to indicate you understand and agree to these conditions. Thank you.

_____ _____

Patient Signature Date