

TELL US ABOUT YOURSELF

First Name _____ **Last Name** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Daytime Telephone _____

Cell / Alternate Phone Number _____

E-mail Address _____

Date of Birth _____ **Male** _____ **Female** _____

Social Security Number (if you have dental insurance) _____

Occupation _____

Business/Employer Name _____

Business Telephone _____ **Business e-mail** _____

Name of General Dentist _____ **Phone Number** _____

Name of Spouse/Domestic Partner (if insurance is involved) _____

Spouse/Domestic Partner Social Security Number _____

Spouse/Domestic Partner Date of Birth _____

If Patient is a Minor, Name of Parent

First Name _____ **Last Name** _____

Employer Name/Address _____

Business Telephone/Other Telephone _____

TELL US ABOUT YOUR HEALTH

First Name _____ Last Name _____

How would you describe your health? Please circle 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 circle 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:

LEVEL OF INTENSITY OF PAIN

1 = Mild, 10 = Severe
Please circle 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 complete information about your dental needs as we diagnose them. We will share our diagnostic processes with you, and we invite and welcome all of your questions regarding our work with you.

Towards this aim of a full, 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 need to have 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. However, it is a biological procedure and results cannot be 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.
- We make special efforts to preserve the crowns of teeth we treat, but despite our best efforts occasionally a porcelain crown may fracture and require a new restoration.
- 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 should be completed **within 30 days of root canal therapy**. Final restorations are provided by your restorative dentist.

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, as they are decided by your insurance company. We collect your estimated co-payment at the time of service and then bill the insurance company for you. Your insurance company may take one to two months to process the claim and any portion not paid for by them is your responsibility and kindly payable within 30 days. Please sign below to indicate you understand and agree to these conditions. Thank you.

Patient Signature

Date