PENINSULA ENDODONTICS
DENTAL GROUP

KINGSTONE C. SHIH, DDS MEHRAN FOTOVATJAH, DDS
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## PATIENT INFORMATION (PLEASE PRINT) :

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. (First Name) _____ (M.I.) ____ (Last Name) _____

Date of Birth (MM/DD/YY): _____ Social Security # _____

Home Address:

Street: _____ Apt. # _____

City: _____ State _____ Zipcode _____

Home Phone# _____ Work# _____ Mobile# _____

**Billing Address if different from above**

Street: _____ Apt. # _____

City: _____ State _____ Zipcode _____

Patient's Employer: _____ Phone # _____

Street: _____ Suite # _____

City: _____ State _____ Zipcode _____

If patient is a full-time college student, name and location of school: _____

Who referred you to our office? _____ Phone# _____

Have you or a family member been treated in our office before? ☐ Yes ☐ No

If yes, with which one of our doctors? _____

**IN CASE OF AN EMERGENCY:**

PLEASE CONTACT: _____ Phone # _____

## DENTAL INSURANCE INFORMATION:

*If you have dental insurance and would like us to submit the claim on your behalf, please provide the following information:*

Name of Subscriber: _____ Name of Employer: _____

Subscriber's ID# _____ (May be SSN) Subscriber's Date of Birth (MM/DD/YY) _____

Relationship to Employee: (please circle one) SELF SPOUSE/PARTNER CHILD

Name of Insurance Company: _____ Group# _____

Street: _____ Suite # _____

City: _____ State: _____ Zipcode: _____ Phone # _____

If you have SECONDARY dental insurance, please provide the following information:

Name of Subscriber: _____ Name of Employer: _____

Subscriber's ID# _____ (May be SSN) Subscriber's Date of Birth (MM/DD/YY) _____

Relationship to Employee: (please circle one) SELF SPOUSE/PARTNER CHILD

Name of Insurance Company: _____ Group# _____

Street: _____ Suite # _____

City: _____ State: _____ Zipcode: _____ Phone # _____

# PATIENT HEALTH HISTORY

General Dentist's Name: _____ Phone # _____

Physician's Name: _____ Phone # _____

Are you presently under a physician's care for a current illness or condition? ☐ Yes ☐ No

List any drugs you are currently taking: _____

List any herbal supplements you are currently taking: _____

Have you ever or are you now taking any of the following? (please circle) Zometa, Aredia, Fosamax, Actonel, Didronel, Skelid, Boniva, Bonefos, or Ostec?

Do you take aspirin daily? ☐ Yes ☐ No

Have you been treated for alcoholism or drug addiction? ☐ Yes ☐ No

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? *(Please Circle)*

| | | | |
|---|---|---|---|
| Diabetes | Yes | No | ➡ If yes, how is it controlled? ☐ Diet ☐ Medication |
| Heart Surgery/Stroke | Yes | No | ➡ Date of Surgery/Stroke: _____ |
| Heart Murmur | Yes | No | |
| Heart Disease/Angina | Yes | No | |
| Rheumatic Fever | Yes | No | |
| Mitral Valve Prolapse | Yes | No | |
| Pacemaker | Yes | No | |
| Artificial Valve | Yes | No | |
| High Blood Pressure | Yes | No | |
| Kidney Disease | Yes | No | |
| Anemia | Yes | No | |
| Peptic/Duodenal Ulcer | Yes | No | |
| Bleeding/Hemophilia | Yes | No | |
| Artificial Joint/Prosthesis | Yes | No | |
| Hepatitis | Yes | No | ➡ Which type? _____ |
| Asthma/Emphysema | Yes | No | |
| Epilepsy | Yes | No | |
| Tuberculosis | Yes | No | |
| Nervous Disorder | Yes | No | |
| Cancer/Tumor | Yes | No | |
| Arthritis | Yes | No | |
| Chronic Sinus | Yes | No | |
| Chronic Depression | Yes | No | |
| Fainting/Dizziness | Yes | No | |
| Thyroid | Yes | No | |
| TMJ Disorder | Yes | No | |
| Chronic Headaches | Yes | No | |
| Chemotherapy/Radiation Therapy | Yes | No | |
| Immunodeficiencies | Yes | No | Date _____ |

Is there anything else in your health history of which we should be aware? Please explain _____

DO YOU PRESENTLY HAVE A TOOTHACHE? ☐ YES ☐ NO

HAVE YOU EVER HAD ROOT CANAL TREATMENT? ☐ YES ☐ NO

Is any part of your mouth sensitive to the following:

| | | |
|---|---|---|
| Hot | ☐ Yes | ☐ No |
| Cold | ☐ Yes | ☐ No |
| Biting/Pressure | ☐ Yes | ☐ No |

Primary complaint _____

Have you ever had an adverse reaction to local anesthetics? ☐ Yes ☐ No

**ARE YOU ALLERGIC TO ANY MEDICATION OR ANTIBIOTICS (PENICILLIN, ETC.)? ☐ YES ☐ NO**

**ARE YOU ALLERGIC TO LATEX OR ANYTHING ELSE THAT WE SHOULD KNOW ABOUT? ☐ YES ☐ NO**

**PLEASE LIST** _____

**OTHER ALLERGIES?** _____

**WOMEN ONLY:**

Are you taking any birth control medication? ☐ Yes ☐ No

**NOTE: ANTIBIOTICS MAY INTERFERE WITH THE EFFECTIVENESS OF ORAL CONTRACEPTIVES.**

Are you or could you be **PREGNANT?** ☐ Yes ☐ No

If you are pregnant, in what month are you of your pregnancy? _____

I, the undersigned (patient or legally responsible party), consent to the dental treatment decided upon to be necessary by the Dentist and myself. I further authorize the taking of radiographs and/or other diagnostic measures appropriate for a thorough evaluation. I understand that if any change occurs in my health I am to report it to the dental office as soon as possible. I have read and understand each question, and have answered all of them truthfully and to the best of my ability. I understand upon completion of root canal therapy in this office, **I MUST RETURN TO MY GENERAL DENTIST FOR PERMANENT RESTORATION.**

Signature of Patient (Parent or Guardian if minor): _____ Date _____

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# INFORMATION ABOUT ENDODONTIC TREATMENT

## WHAT ARE MY ALTERNATIVES?

Endodontic treatment has been recommended as a procedure to be done on your tooth in an attempt to retain a tooth that may otherwise require extraction. Your alternatives to the proposed treatment are to have no treatment done or to have the tooth extracted. If no treatment is done, there is the risk of infection, pain and loss of the tooth. If the tooth is extracted, then some form of an artificial replacement tooth may be constructed.

## WHAT ARE THE POSSIBLE COMPLICATIONS?

Complications **are rare**. While no complications may be expected as a result of the proposed endodontic treatment, it is possible that complications may still occur with your care. Most of the complications that can occur are a normal consequence of treating teeth that have problems similar to yours. These complications may require additional treatment.

Some of the possible complications include, but are not necessarily limited to, the following possibilities: mild to severe pain, infection, swelling, fever, difficulty opening or closing the jaw, fractures, access complications, calcified canals or separated instruments. There is also a possible risk of loss of sensation (numbness) which could be either temporary or permanent.

Endodontic treatment is a highly successful procedure for retaining teeth that would otherwise be extracted. Unfortunately, not all teeth will respond favorably to the treatment. Consequently, it is possible that your tooth may in the future require additional treatment such as another endodontic treatment, surgery, or even extraction.

Medications may be given for pain or infection. If given pain medication, you should not drive an automobile nor operate equipment that may be hazardous to yourself or others. If you are a female who is taking birth control pills, it is possible that you could become pregnant while taking an antibiotic. Consequently, an alternative form of contraception may be appropriate while taking the antibiotic.

**To protect your tooth from decaying or fracturing, you will need to return to your dentist for a permanent filling or crown.**

## CONSENT FOR TREATMENT

I have read the above and I understand that no treatment is without some measure of risk and the risks of the proposed treatment have been explained to me. I prefer to undergo the ENDODONTIC (root canal) procedure in order to attempt to retain my tooth. Consequently, I hereby authorize the Doctors and their assistants to perform the necessary endodontic procedures which have been described to me. I further request and authorize them to do whatever they deem advisable and necessary as a result of unforeseen circumstances.

Signed (Patient/Legal Guardian): _____ Date: _____