Excel Endodontics

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Patient Consent To Treatment

THE PROPOSED TREATMENT

Root canal treatment (also called Endodontic treatment) involves relieving pain and discomfort by removing the nerve tissue (**pulp**) located in the center of the tooth and its root or roots (**the root canal**). Treatment involved drilling through the biting surface of the tooth to expose the pulp, which is removed with very fine metal files. Medications may be used to disinfect the interior of the tooth to prevent further infection.

Each empty root canal is filled with medicated material (**gutta percha**). The opening in the tooth is closed with a temporary filling. Once the root canal treatment is completed, it is **essential** to return to the general dentist promptly to have a permanent restoration. Because a temporary seal is designed to last only a short time, failing to return as directed to have the tooth sealed permanently with a crown could lead to the deterioration of the seal, resulting in decay, infection, gum disease, and possible loss of the tooth due to fracture.

Twisted, curved, or blocked root canals may prevent removal of all inflamed or infected pulp. Since leaving any pulp in the root canal may cause your symptoms to continue or worsen, this might require an additional procedure called an ***Apicoectomy & Retrograde Filling.*** Through a small opening cut in the gums and surrounding bone, any remaining pulp is removed and the root canal is sealed. Apicoectomy may also be required if your symptoms continue and your tooth does not heal.

COMMON RISKS

1. Bleeding, pain, soreness and infection: During and after treatment you may experience bleeding, pain, swelling, or discomfort for several days, which may be treated with pain medication. You may also experience an infection following treatment, which would be treated with antibiotics.

2. Reaction to anesthesia: During treatment you will receive a local anesthetic, which in rare instances patient may have prolonged numbness and/or irritation in the area of injection.

3. Broken instrument: Very rarely, a root canal instrument will break off in the root canal that is twisted, curved or blocked with calcium deposits. Depending on its location, the fragment can be retrieved or it may be necessary to seal it in the root canal (these instruments are made of sterile, non-toxic surgical stainless steel, so this causes no harm). It may also be necessary to perform an apicoectomy to seal the root canal.

4. Overfill: As a result of filling in the root canal, the incomplete formation of your tooth or an abscess at the end of the tooth (apex), an opening may exist between the root canal and the bone or tissue surrounding the tooth. This apicoectomy may be necessary for retrieving the filling material and sealing the root canal.

5. Need for further treatment: Teeth that receive root canal treatment may be more prone to cracking over time, which may require a bridge or partial denture. In some cases, root canal treatment may not relieve all symptoms. If you suffer from gum disease (periodontal disease), this can increase the chance of losing a tooth even though root canal treatment was successful.

IF YOUR TOOTH IS DETERMINED TO BE NON-SALVAGEABLE DURING:

1. Root Canal Therapy: if decay is found to have destroyed a large portion of the tooth structure above the gumline or if a pre-existing condition is discovered (i.e. root fracture, blocked or perforated canals), which would severely compromise the prognosis of the tooth, then extraction of the tooth by your General Dentist will be recommended. The patient would be responsible for an exploratory partial endodontic therapy fee of **$300** (which may not be covered by insurance) instead of the root canal therapy fee.

2. Root Canal Retreatment: if the remaining tooth has a poor prognosis following removal of all preexisting restorative materials (buildups, post, pins, post/core, silver points, thermafil points, paste, separated instruments, gutta-percha, etc) and exploration for additional untreated canals is attempted. The patient would be responsible for an exploratory or disassembly retreatment fee of **$300** (which may not be covered by insurance) instead of the retreatment fee.

Every reasonable effort will be made to ensure that your condition is treated properly, although it is not possible to guarantee perfect results. By signing below, you acknowledge that you have received adequate information about the proposed treatment, that you understand this information and that all your questions have been answered fully.

Patient, Parent or Responsible Party (print) _____ Relationship to Patient _____

Patient, Parent or Responsible Party (signature) _____ Date ____/____/____

Office Use: Reviewed by Dr. (signature) _____ Date ___/___/___ Witness _____