ROOT CANAL DENTISTS

A root canal practice accepting
Medicaid/CHIP/most PPO Insurance

MEDICAL AND PERSONAL HISTORY

Last First MI Today's Date_____

Name_____ Age_____ Mr. Mrs Ms Dr

Address_____ Home Phone_____

City, State, Zip_____ Work Phone_____

Sex: M F Patient SS#_____ Cell Phone_____

Date of Birth___/___/____ Responsible Party_____ Referring Dentist_____

Employer _____ Current Position_____

Dental Insurance Carrier_____ Group #_____

Employer that Carries Benefits_____

Medical History Circle all that applies, present and past

Date of Last Medical Exam _____

Heart Trouble	Lung Disease	Stroke	Hepatitis A	Asthma
High Blood Pressure	Tuberculosis	Anemia	Hepatitis B	Sinus Trouble
Heart Murmur	Kidney Trouble	Diabetes	Jaundice	Liver Disease
Heart Valve Problem	Allergy or Hives	Hemophilia	Epilepsy	Seizures
Drug Addiction	Mitral Valve Prolapse	Thyroid Disease	TMJ Pain	Rheumatic Fever
Blood Transfusion	Bleeding Problem	Latex Allergy	AIDS/ HIV+	Heart Pacemaker
Cortisone Therapy	Cancer/Leukemia	Chemotherapy	Artificial Joint	Venereal Disease

*** Do you have any disease or condition not listed?** **Yes** **No**

Please list_____

*** Are you allergic to any medication or anesthetic injection?** **Yes** **No**

Please list medications and reaction_____

_____

*** Do you routinely need antibiotics before dental treatment?** **Yes** **No**

Please list the name and amount of antibiotic you usually take_____

*** Are you under the care of a physician now?** **Yes** **No**

If yes, for what?_____

*** If female, are you pregnant, breast-feeding, or taking oral contraceptives?** **Yes** **No**

Please list ALL medications, vitamins, and supplements taken in the last 3 days, with dosages. (Include Aspirin, herbal supplements, oral contraceptives, etc.)

_____

_____

Family Physician's Name _____ Phone #_____

Preferred Pharmacy_____ Phone #_____

Person to contact in case of emergency _____ Phone #_____

I have answered these questions truthfully and accurately. Should subsequent visits occur I agree to inform my treating Doctor of any changes in my health status, medication, address or phone numbers, or insurance information. I understand that failure to disclose medical and medication history may result in the immediate termination of doctor/patient relationship at the discretion of Root Canal Dentists.

*Patient Signature*_____ *Date*_____

*Doctor Initials*_____

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Guardian Agreement

To best respond to the needs of your child, we offer two choices. Please check one of the following:

- ☐ **If you wish to remain in the treatment room, we encourage you to be a silent helper. By choosing this option, you understand that you will not interfere with the doctor, assistant, or child while treatment is being performed, no cell phone use and must remain seated throughout the whole treatment. If you are not able to comply, you will be asked to leave the room or treatment will be stopped.**

- ☐ **If you are not comfortable or think that your child will do better alone, please remain in the waiting room.**

- ❖ **A parent or legal guardian must remain in the office during treatment at all times.**

I (We) have read the above and was/were given the opportunity to ask additional questions. I (we) freely give my (our) informed consent.

Patient Name: _____ Date of Birth: _____

Guardian's Signature: _____ Contact #:_____

Printed Name: _____ Relationship: _____

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CONSENT FOR ENDODONTIC CONSULTATION, X-RAYS, DIAGNOSIS AND/OR TREATMENT

I, _____, (print name) understand that all procedures and treatments have inherent and potential risks. These risks include, but are not limited to complications resulting from the use of dental instruments, drugs, sedation, medicines, pain killers, anesthetics, and injections. These complications include, but are not limited to: swelling, sensitivity, bleeding, bruising, pain, infection, cold sores, changes in bite; jaw muscle/joint difficulty, referred pain to ear, neck and head, numbness and tingling sensation in areas of the mouth which is transient, but on rare occasions may be permanent; loosening or damage of teeth, crowns, or bridges; allergic reactions; delayed healing; sinus problems; the possibility of instruments broken within the root canals, extra openings of the crown or root of the tooth, filling material extending past the end of the roots, there may be periods of discomfort during or following treatment.

Many factors contribute to the success or failure of root canal therapy, which cannot be determined in advance. Therefore, in some cases treatment may have to be changed, discontinued before it is completed, or may fail following treatment. Some of these factors include, but not limited to: the shape and location of the canal anatomy, blocked canals due to filling or prior treatment, natural calcification, broken instruments, periodontal (gum) involvement, or an undetected or after the fact split (crack) in the tooth; also, my resistance to infection, my failure to keep scheduled appointments, my failure to obtain permanent restoration following treatment.

I further understand that prescribed medications and drugs may cause drowsiness, nausea, vomiting, and lack of awareness and coordination, which may be exaggerated by the use of alcohol, tranquilizers, sedatives or other drugs. The use of antibiotic drugs may have an adverse action on the effect of birth control pills.

I have been given the opportunity to have my questions answered. I understand that I will always have the option to discontinue treatment or elect extraction as opposed to accepting and continuing the recommended treatment. I understand that root canal treatment is an attempt to salvage a tooth, which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth, which has had root canal therapy, may require re-treatment, surgery, or even extraction.

I have been truthful and accurate in the health history and personal information I provided to Root Canal Dentists. If there is a change in health or in medications taken, I will inform Root Canal Dentists at my next appointment. I also accept these procedures outlined above and understand the need for such treatment as well as possible complications and the fees involved.

Patient Name: _____ Date of Birth: _____

Signature_____ Date_____
(Parent, Guardian, or Agent must sign for patients under the age of 18)

Witness _____ Tooth# _____
(Initials)

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Nitrous Oxide/ Oxygen Inhalation Sedation Patient Consent Form

To help lower your anxiety during dental treatment and contribute in making your appointment(s) more pleasant, inhalation (breathing) sedation using a combination of nitrous oxide (sometimes called laughing gas) and oxygen (hereafter N_2O) is available. Typically most patients find the nitrous oxide to be effective at controlling their anxiety with little to no ill effects. However, in some cases, the level of effectiveness can be unpredictable and in rare cases patients may experience undesirable reactions to N_2O despite our best efforts to minimize this from happening. These problems include – but are not limited to – nausea and vomiting, allergic reactions, breathing problems, heart problems and blood pressure problems. On very rare occasions, patients have had to be hospitalized with a life- threatening problem.

FEMALES:
If you suspect you are pregnant, it is critical that you inform us immediately! The use of N_2O is a possible risk to your unborn baby; therefore we advise AGAINST the use N_2O during pregnancy. There is a risk for sudden miscarriage or loss of the baby if you use nitrous oxide during your pregnancy.

I understand that I should not eat or drink 4 hours prior to using N_2O to reduce the possibility of undesirable reactions mentioned above, particularly nausea and vomiting.

I (We) have read the above and was/were given the opportunity to ask additional questions. I (we) freely give my (our) informed consent for the use of nitrous oxide/oxygen during dental treatment at Root Canal Dentists. I (we) understand that no guarantees are made regarding any medical or mental results associated with use of this sedation technique.

_____ I (we) also understand that the cost for N_2O is **$40 per visit, excluding Medicaid/ Chip** patients, which will be collected **prior** to treatment because this inhalation sedation treatment is separate from my dental treatment and is not covered by my (our) insurance policy.

Patient Signature _____ Date _____

Patient Printed Name _____

_____Check if you are the parent or guardian of the named patient (if patient is under 18 y.o.)

Guardian's Signature _____ Contact #: _____

Printed Name _____Relationship _____

Doctor's Signature_____ Assistants' Signature_____

Form of Payment: MC, VS, AMEX, DISC, Check, Cash

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In our efforts to comply with the Health Information Privacy Act, HIPAA, we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Please circle your response to the following:

May we leave messages concerning your appointments / treatment with a co-worker, receptionist or secretary that your calls?	YES	NO	N/A regularly answers
May we leave messages on a voice mail at work'?	YES	NO	N/A
May we leave messages on an answering machine at home?	YES	NO	N/A
May we discuss your appointments *I* treatment with your spouse?	YES	NO	N/A
For any children above the age of 18, still living at home, may we discuss your appointments / treatment with your parent(s) or guardian?	YES	NO	N/A

You must inform us, in writing, of any changes in your directives. This record takes effect April 14, 2003 and will be kept in your file along with your acknowledgement of receipt of your Notice of Privacy Practices.

Signature:_____Date:_____

Witness:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____Please Print Name

Signature Date

_____

For **Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to Sign
- Communications bafflers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify) _____

_____

_____

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