Prudent ENDODONTICS

ROOT CANAL THERAPY & MICROSURGERY

Patient Name: _____ Date: _____

Parent/Guardian Name: _____ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Text: Y/N

Work Phone: _____ Email: _____

M/F (Please Circle) SSN: _____ DOB: _____

How did you hear about our office? _____

Referring Dentist: _____

Pharmacy: _____ Pharmacy Phone # _____

Primary Insurance:

Insurance company: _____ Group # _____

Name of Policy Holder: _____ Relationship: _____

Policy Holder SSN/ID# _____ Policy Holder DOB: _____

Employer/Group Name: _____

Employer Address: _____ Employer Phone: _____

Secondary Insurance:

Insurance company: _____ Group # _____

Name of Policy Holder: _____ Relationship: _____

Policy Holder SSN/ID# _____ Policy Holder DOB: _____

Employer/Group Name: _____

Employer Address: _____ Employer Phone: _____

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Medical History

Patient Name: _____ **Birth Date:** _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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 currently under a physician's care? YES____ NO____
If yes, please explain_____

Have you ever been hospitalized or had a major operation? YES____ NO____
If yes, please explain_____

Are you taking any medications, pills, or drugs? YES____ NO____
If yes, please explain_____

Do you or have you ever taken Phen-Fen or Redux? YES____ NO____ Type: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? YES____ NO____ Type: _____

Are you on a special diet? YES____ NO____

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

AIDS/HIV Positive	YES____ NO____	Hemophilia	YES____ NO____
Alzheimer's Disease	YES____ NO____	Hepatitis A	YES____ NO____
Anaphylaxis	YES____ NO____	Hepatitis B or C	YES____ NO____
Anemia	YES____ NO____	Herpes	YES____ NO____
Angina	YES____ NO____	High Blood Pressure	YES____ NO____
Arthritis/Gout	YES____ NO____	High Cholesterol	YES____ NO____
Artificial Heart Valve	YES____ NO____	Hives or Rash	YES____ NO____
Artificial Joint	YES____ NO____	Hypoglycemia	YES____ NO____
Asthma	YES____ NO____	Irregular Heartbeat	YES____ NO____
Blood Disease	YES____ NO____	Kidney Problems	YES____ NO____
Blood Transfusion	YES____ NO____	Leukemia	YES____ NO____
Breathing Problems	YES____ NO____	Liver Disease/ Yellow Jaundice	YES____ NO____
Bruise Easily	YES____ NO____	Low Blood Pressure	YES____ NO____
Cancer	YES____ NO____	Lung Disease	YES____ NO____
Chemotherapy	YES____ NO____	Mitral Valve Prolapse	YES____ NO____
Chest Pains	YES____ NO____	Osteoporosis	YES____ NO____
Cold Sores/Fever Blisters	YES____ NO____	Pain in Jaw Joints	YES____ NO____
Congenital Heart Disorder	YES____ NO____	Psychiatric Care	YES____ NO____
Cortisone Medicine	YES____ NO____	Radiation Treatments	YES____ NO____
Diabetes	YES____ NO____	Recent Weight Loss	YES____ NO____
Drug Addiction	YES____ NO____	Renal Dialysis	YES____ NO____
Emphysema	YES____ NO____	Rheumatic Fever	YES____ NO____
Epilepsy or Seizures	YES____ NO____	Rheumatism	YES____ NO____
Excessive Bleeding	YES____ NO____	Shingles	YES____ NO____
Excessive Thirst	YES____ NO____	Sickle Cell Disease	YES____ NO____
Fainting Spells/ Dizziness	YES____ NO____	Sinus Trouble	YES____ NO____
Frequent Cough	YES____ NO____	Spina Bifida	YES____ NO____
Frequent Headaches	YES____ NO____	Stomach Intestinal Disease	YES____ NO____
Glaucoma	YES____ NO____	Stroke	YES____ NO____
Hay Fever	YES____ NO____	Swelling of Limbs	YES____ NO____
Heart Attack	YES____ NO____	Thyroid Disease	YES____ NO____
Heart Murmur	YES____ NO____	Tonsillitis	YES____ NO____
Heart Pacemaker	YES____ NO____	Tuberculosis	YES____ NO____
Heart Trouble/Disease	YES____ NO____	Ulcers	YES____ NO____
		Venereal Disease	YES____ NO____

Have you ever had any serious illness not listed above? YES____ NO____ If yes, please explain_____

Comments:_____

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ASNWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY (OR PATIENTS) HELATH. IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MEDICAL STATUS.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____ **DATE**_____

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Patient Consent Form for Endodontic Treatment

Patient's Name_____ Date of Birth_____

Type of Procedure Tooth#____ **Root Canal Treatment ___ Retreatment ___ Pulpal Regeneration___**

- I understand that root canal therapy is a procedure to retain a tooth which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, many factors contribute to its success or failure which may not be determined in advance. Therefore, a tooth which has had root canal therapy may require retreatment, surgery, or even extraction. Some of these factors include, but not limited to: resistance to infection; the shape and location of the root canal treatment; failure to keep scheduled appointment or failure to have the tooth restored promptly after completion of the treatment.

- I understand that complications of endodontic therapy may include, but are not limited to the Possibility of instruments being separated within the root canals; perforations (extra opening) of the crown or root of the tooth; damage to existing filings; crowns or bridges; fracture of the tooth; discomfort; jaw muscle cramps and spasms, temporomandibular (jaw) joint difficulty; swelling and pain. During and after treatment complications may be discovered which make treatment impossible or by which may require endodontic surgery or extraction of the tooth.

-I understand that complications of anesthesia, infection, prescribed analgesics (pain relievers) and medicines (antibiotics) may include, but not limited to: swelling, infection, bleeding, discoloration of the face, discomfort, pain, nausea, drowsiness, allergic reactions, numbness or tingling of the lip gum or tongue (this condition is usually temporary).

- I've been informed of possible alternative treatment methods including extractions or no treatment

-I understand that during and following treatment, I am to contact Dr. Rinku Parmar, if I have any additional questions or experience any unexpected reactions. It will be my responsibility to contact my Family Dentist for the restoration of my tooth (permanent filling, crown, etc.).

-I have been given the opportunity to question Dr. Parmar concerning the nature of the treatment, the inherent risks of the treatment, and the alternative to this treatment. This consent form is a summary and does not encompass the entire discussion I had with the doctor regarding the proposed treatment.

I hereby authorize Dr. Parmar to treat my tooth. I hereby give the permission for the use of radiographs and/or photographs taken during the course of treatment to be used to require documentation purposes.

Patient's Signature (signature of Legal Guardian_____ Date_____

Witness Signature:_____ Date_____

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Patient Financial Responsibility Agreement

I understand and agree that I will be financially responsible for the patient services provided by the office of Prudent Endodontics, according to the policies stated in this document.

Co-pays are due at the time of service. Prudent Endodontics will verify eligibility and bill you insurance out of courtesy to you but it is your responsibility to be sure you are covered for provided services. Any predeterminations or out of pocket estimates are not a guarantee of payment.

Once insurance has paid, if a balance remains on my account, unpaid after 60 days, I can be charged an additional fee of 18%.

If my check is returned for insufficient funds I can be assessed with a processing charge. If that should occur, patient may be asked to make new payment arrangements with our office.

Patient Signature **Date**

HIPAA Consent

I, _____, have viewed the posted Notice of Privacy Practices for Prudent Endodontics and have been advised of my rights to have a written copy if I choose.

_____ I request a written copy of the Notice of Privacy Practices

_____ I agree to us sending electronic e-referrals including PHI and x-rays, if needed. We also send electronic claims to your dental insurance, which include PHI to receive payment for services provided.

_____I give permission to call in any prescriptions and share information with the pharmacist when necessary. Also, to give reminders for any pre-medication needed prior to treatment.

_____I give my permission for Prudent Endodontics to discuss and/or release dental account or record information with the following:

By signing below, I agree that, I have been offered the HIPPA policy, and understand and acknowledge my agreement to the terms set forth in the HIPPA information and consent.

Patient Signature **Date**