

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: \_\_\_\_\_

### 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?

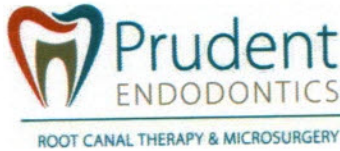
AIDS/HIV Positive	YES ___ NO ___	Hemophilia	YES ___ NO ___
Alzheimer's Disease	YES ___ NO ___	Hepatitis A	YES ___ NO ___
Anaphylaxis	YES ___ NO ___	Hepatitis B or C	YES ___ NO ___
Anemia	YES ___ NO ___	Herpes	YES ___ NO ___
Angina	YES ___ NO ___	High Blood Pressure	YES ___ NO ___
Arthritis/Gout	YES ___ 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 ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY (OR PATIENTS) 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 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 fillings; 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

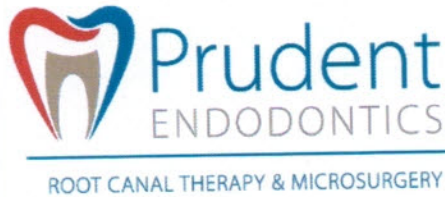
- I understand that during and following treatment, I am to contact Dr. Rinku Parmar, if I have any additional questions or experience any unexpected reactions. It will be my responsibility to contact my Family Dentist for the restoration of my tooth (permanent filling, crown, etc.).

- 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 \_\_\_\_\_



### 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.

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**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:

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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.

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**Patient Signature**

**Date**