PATIENT INFORMATION

Patient's Name_____

Home Address_____ **SSN**_____

City, State, Zip_____ **Date of Birth**_____

Occupation_____ **Home Phone**_____

General Dentist _____ **Mobile Phone**_____

IF PATIENT IS A MINOR:

Parent/Guardian Name _____ **Home Phone**_____

SSN_____ **Date of Birth**_____

MEDICAL HISTORY

Do you have, or have you had, any of the following? (Please circle)

Heart Murmur/MVP	**Migraine/Headaches**	**Are you taking any medications?**
Heart Disease	**Currently Pregnant/Breast Feeding**	**YES NO**
High Cholesterol	**Herpes/Cold Sores**	**Please List:** _____
High Blood Pressure	**Immunocompromised**	_____
Liver Disease	**Chest Pain/Heart Attack**	_____
HIV Positive	**Stroke**	_____
Diabetes	**TMJ Problems**	**Do you have any Allergies? YES NO**
Lung Disease/Asthma	**Pacemaker**	**Aspirin Codeine**
Excessive Bleeding	**Prosthetic Implant**	**Penicillin Latex**
Thyroid Problems	**Joint Replacement**	**Local Anesthetic Sulfa**
Hepatitis (A, B, C)	**Arthritis**	**Please List:** _____
Tuberculosis	**Anxiety/Depression**	_____
Epilepsy/Seizures	**Radiation/Chemotherapy**	_____

Do you have any other medical conditions? _____

Are you under medical treatment now? _____

Have you had surgery in the last 5 years? _____

Do you premedicate or routinely take antibiotics before dental treatment? YES NO

Physician's Name _____**Phone**_____

Notify in case of an emergency _____**Phone**_____

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** _____

****PLEASE TURN OVER AND SIGN****

BAYSIDE ENDODONTICS

ENDODONTIC CONSENT AND HIPAA AUTHORIZATION

We would like out patients to be informed about the various procedures involved in endodontic therapy and gave their consent before starting treatment. Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by root canal therapy or endodontic surgery. The following discusses possible risk that may occur from endodontic treatment and other treatment choices.

RISKS: The risk include: The possibility of an instrument separating within or outside the root canals; perforations (extra openings) of the crown or root of the tooth; damage to bridges, existing fillings, crowns, or porcelain veneers, loss of tooth structure in gaining access to canals; paresthesia or (permanent numbness) and cracked or fractures teeth; missed canals; continued infection which may require additional treatment or rarely, hospitalization. During the treatment complications may be discovered which make treatment impossible, or which may require dental surgery. Theses complications may include: block canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), or splits or fractures of teeth.

MEDICATIONS: Prescribed medications including the use of nitrous oxide (laughing gas), and other drugs may causes drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers sedative or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effect.

OTHER TREATMENT OPTIONS: These include no treatment (waiting for more definite development of symptoms) or tooth extraction. Risks involved in these choices might include pain, infection, swelling and loss of teeth and the spread of infection to other areas.

OUR PAYMENT POLICY: The best patient-doctor relationships are maintained when there is a complete understanding of the treatment rendered and the fee. Please feel free to discuss the treatment or the fee with us at any time.

Our Payment Policy is as follows: **Payment is due on the day of treatment**. Primary insurance will be filed as a courtesy. The patient is responsible for any insurance co-payments and deductible amounts at the time of service. The patient will also be responsible for any related collections costs that pertain to the collection of this debt and interest on pas due accounts.

When endodontic therapy is completed, your tooth will require a permanent restoration. The endodontic fee **DOES NOT** include this service. Your referring general dentists will render this service which is mandatory for the preservation of your tooth and the success of the root canal therapy.

CONSENT: I, the undersigned, being the patient (parent or guardian of minor patient) consent to the performing of the procedures decided upon to be necessary or advisable in the opinion of the doctor. **I also understand that upon completion of root canal therapy in this office I shall return to my general family dentist for a permanent restoration of the tooth involved. The permanent restoration (crown, onlay or composite / resin filling) must be completed within 30 days to prevent infection or fracture of the tooth.**

I agree to be responsible for all charges for dental services not paid by my dental benefit plan, unless Bayside Endodontics has a contractual agreement with my pain prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I authorize payment to my doctor.

I authorize my doctor to retrieve and send all pertinent information to my general dentist. I authorize use of this form on all submissions. I understand no information from my dental records will be release to anyone outside this office without my written permission.

"I have read and understand the above, and hereby consent to treatment"

Signature of the responsible party_____ **Date**_____