Medical History

PATIENT INTAKE FORM

Patient's name: _____ **Nickname:** _____

Street address: _____ **Date of birth:** _____

City, state & zipcode: _____ **Social Security:** _____

Occupation: _____ **Mobile Phone:** _____

General dentist: _____ **Email:** _____

****Please mark any of the following conditions you may currently have.**

- ☐ **Heart disease**
- ☐ **Heart murmur/MVP**
- ☐ **High blood pressure**
- ☐ **High cholesterol**
- ☐ **Chest pain**
- ☐ **Heart attack**
- ☐ **Stroke**
- ☐ **Pacemaker**
- ☐ **Joint replacement**
  on date: _____
- ☐ **COPD**
- ☐ **Diabetes type I | Diabetes type II**
- ☐ **Thyroid problems**
- ☐ **Asthma**
- ☐ **Epilepsy | Seizures**
- ☐ **Glaucoma**
- ☐ **Immunocompromised**
- ☐ **Current smoker**
- ☐ **Past smoker**
- ☐ **Hepatitis**
- ☐ **Herpes | Cold sores**
- ☐ **HIV positive**
- ☐ **Currently pregnant | Breast feeding**
- ☐ **Migraine / Headache**
- ☐ **TMJ problems**
- ☐ **Arthritis**
- ☐ **Anxiety**
- ☐ **Depression**
- ☐ **Stomach Ulcers**
- ☐ **Cancer**
  type: _____
- ☐ **Chemotherapy**
- ☐ **Radiation**

Do you have any other medical conditions? (If so, please list) _____

Have you had surgery in the last 5 years? _____

Are you required to pre-medicate with antibiotics before dental treatment due to your medical history (i.e. history of sepsis, joint replacements, immunocompromised, etc. ☐ **YES** | ☐ **NO**

Have you ever taken any medication for osteoporosis (such as Actonel, Boniva, Prolia, etc.)? ☐ **YES** | ☐ **NO**

Are you taking any medications?

☐ **YES** ☐ **NO**

Please List:_____

_____

_____

_____

_____

_____

Do you have any allergies?

☐ **YES** ☐ **NO**

- ☐ **Latex**
- ☐ **Penicillin**
- ☐ **Local anesthetic**
- ☐ **Ibuprofen/NSAIDS**
- ☐ **Sulfa**
- ☐ **Codeine**
- ☐ **Bleach**

Please List: _____

_____

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 responsible party: _____ **Date:** _____

Endodontic Consent

We aim to provide our patients with comprehensive information regarding the procedures involved in endodontic therapy to ensure their informed consent prior to treatment initiation. Endodontic therapy, commonly known as root canal therapy, is undertaken with the primary goal of preserving a tooth that might otherwise necessitate extraction. This preservation can be achieved through either root canal therapy or endodontic surgery. The subsequent section outlines potential risks associated with endodontic treatment, as well as alternative treatment options:

- **Pain, discomfort, swelling, bleeding; antibiotics may be needed to treat any associated infections**
- **Possibility of an instrument separating within or outside the root canals**
- **Perforations (extra openings) of the crown or root of the tooth**
- **Missed canals**
- **Damage to bridges, existing fillings, crowns, or porcelain veneers, cracked or fractured teeth, loss of tooth structure in gaining access to canals**
- **Paresthesia (temporary or permanent numbness) and trismus (restricted mouth opening)**
- **Continued or persistent infection which may require additional treatment (surgery or extraction) or rarely, hospitalization**
- **During the treatment complications (e.g., blocked canals, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), or splits or fractures of teeth) may be discovered which may render treatment impossible, or which may require dental surgery**
- **Treatment can sometimes fail for several reasons. If so, other procedures such as re-treatment, surgery, or extraction may be needed**
- **If extraction is required, the tooth may need to be replaced by an implant, bridge, or removable partial denture**
- **If I choose no treatment, my condition may worsen and I may risk serious injury, including pain, infection, swelling, loss of this tooth and the spread of infection to other areas**
- **Once root canal treatment is completed, I must have a permanent restoration placed by my regular dentist within 30 days. If I fail to have the tooth restored, I risk a failure of the root canal treatment, decay, infection, tooth fracture and/or loss of the tooth. If I do not return to my general dentist for final restorative, and my root canal treatment must be redone, I will be responsible for the full fee of retreatment.**

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

I acknowledge that I have provided accurate medical history and will follow treatment recommendations. I have had the opportunity to ask questions about root canal treatment and risks associated with the procedure. I consent to the performing of the procedures decided upon to be necessary or advisable in the opinion of the doctor.

Signature of responsible party _____ **Date** _____

Financial & Hipaa Consent

FINANCIAL POLICY:

PAYMENT IS DUE ON THE DAY OF SERVICE. Primary insurance is filed as a courtesy. The patient is responsible for any insurance co-payments and deductible at the time of service.

Insurance is ESTIMATED on the information provided by your insurance company. It is the patient's responsibility to understand their insurance coverage with their specific plans. It is also the responsibility of the patient for any unpaid insurance portions, related collections cost, and interest on past due accounts.

I authorize my doctor to act as my agent in helping me obtain payment from my insurance company. I authorize payment to my doctor.

Any charges remaining unpaid sixty days after the date of service or sixty days after insurance payment are considered past due. If no efforts are made to pay the balance due, it will be sent to a collection's agency.

HIPPA STATEMENT:

I authorize my doctor to retrieve and send all pertinent information to my general dentist and all referring doctors that are involved in my treatment. I authorize the use of this form on all submissions. I understand no information from my dental records will be released to anyone outside of this office without my written permission.

Please list persons authorized to discuss and receive medical records:

NAME:_____ **RELATIONSHIP** _____

NAME: _____ **RELATIONSHIP** _____

COMMUNICATION PREFERENCE:

I authorize my dental information to be communicated by:

- ☐ **Voicemail**
- ☐ **Text**
- ☐ **Email**
- ☐ **Home mailing address**
- ☐ **All the above**

I have read and understand the above policies.

Signature of responsible party _____ **Date** _____