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Diplomate
American Board of Endodontics

TELL US ABOUT YOURSELF

First Name _____ **Last Name** _____

Male _____ **Female** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Preferred Telephone Number (_____) _____-_____ cell home office

Alternate Telephone Number (_____) _____-_____ cell home office

E-mail Address _____

Date of Birth _____/_____/_____

Social Security Number (if you have dental insurance) _____-____-_____

Occupation _____

Business/Employer Name _____

Name of General Dentist _____

TELL US ABOUT YOUR DENTAL SYMPTOMS

First Name _____ Last Name _____

1. Are you experiencing any pain at this time? Yes ___ No ___
2. If yes, can you locate where the pain originated? Yes ___ No ___
3. If so, what area? Please circle: Upper/Lower Left/Right Front/Back
4. When did you first notice the symptoms? _____
5. Did symptoms occur suddenly or gradually? _____

Please check the word or words below that best describe your pain:

LEVEL OF INTENSITY OF PAIN	**FREQUENCY OF PAIN**	**QUALITY OF PAIN**
1 = Mild, 10 = Severe Please Circle a Number 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 - 10	__ Constant __ Intermittent __ Momentary __ Occasional	__ Sharp __ Dull __ Throbbing __ Steady

Are you taking pain killers or antibiotics for the tooth? Yes _____ No_____

If yes, what is the name of the medication? _____Who prescribed the medication? _____When did you take the last dose? _____

Is there anything you can do to relieve the pain? Yes ___ No ___

If yes, what? _____

Is there anything you do that causes the pain to increase? Yes ___ No ___

If yes, what? _____

When eating or drinking, is the tooth in question sensitive to: Heat _____ Cold ___ Sweets ___

Does the tooth hurt when you bite down or chew? Yes ___ No ___

Does it hurt if you press the gum tissue around this tooth? Yes ___ No ___

Does a change in posture (lying down or bending over) cause your tooth to hurt? Yes ___ No ___

6. Do you grind or clench your teeth? Yes ___ No ___
7. If yes, do you wear a night guard, day guard, or Invisalign? Yes ___ No ___
8. Has a restoration (filling or crown) been placed on this tooth recently? Yes ___ No ___
   If so, when? _____ and by who?_____
9. Prior to this appointment, has root canal therapy been started on this tooth? Yes ___ No ___
   If so, when? _____ and by who?_____
10. Is there anything else we should know about your teeth, gums or sinuses that would assist us in our diagnosis? _____

Signature of Patient (or Parent) _____ Date _____/_____/_____

TELL US ABOUT YOUR HEALTH

First Name _____ Last Name_____

How would you describe your health? Please circle one. **Excellent** **Good** **Fair** **Poor**

When did you have your last physical examination? _____

Are you currently being treated for any illness or medical condition? Yes ___ No ___

If yes, please describe _____

_____

Name of physician: _____

Have you had surgery in the last 5 years? Yes ___ No ___

What type of surgery did you have? _____

When did you have this surgery? _____

Are you taking blood thinners? Yes___ No___

Have you had a stroke or heart attack? Yes___ No___

Have you ever had any trouble with prolonged bleeding after surgery? Yes ___ No ___

Do you wear a pacemaker or any other kind of prosthetic device? Yes ___ No ___

Have you ever taken Fen-Phen, Redux or any other diet drugs? Yes ___ No ___

Are you taking any medications, drugs or herbs at this time? Yes ___ No ___

If yes, list the medications, drugs or herbs you are taking:

_____

Why are you taking these medications, drugs or herbs? _____

Do you have to pre-medicate with antibiotics prior to any medical or dental procedures? Yes_____ No_____

If yes, name of antibiotic _____

Have you ever had an unusual reaction to anesthetic or do you have any drug allergies? Yes_____ No_____

If yes, please explain _____

Are you now or have you ever taken bisphosphonates (e.g., Fosamax, Boniva, Reclast, Evista)

If yes, please explain _____

Are you allergic to Latex? Yes_____ No_____ Are you allergic to iodine? Yes ___No_____

Please circle any present or past illness you have or have had:

Alcoholism	Cancer	Head/Neck Injuries	Infectious Diseases	Respiratory
Allergies	Diabetes	Heart Disease	Kidney	Rheumatic Fever
Anemia	Drug Dependency	Hepatitis	Liver	Sinusitis
Asthma	Epilepsy	Herpes	Mental	Ulcers
Blood Pressure	Glaucoma	Immunodeficiency	Migraine	Venereal Disease

If female, are you pregnant? Yes ___ No ____

Is there any other information that we should know about your health?

_____

Signature of Patient (or Parent) _____ Date _____/_____/_____

Dental Insurance Information

(Please fill out this form if you have dental insurance)

Patient's Name: _____

Name of Insured Person: _____ (If different from patient)

Insured's DOB ____/____/_____ SSN: (_____)-(___)-(_____) (If different from patient)

Relationship to Patient: Self ___ Spouse ___ Domestic Partner ___ Parent ___

If insured is someone other than yourself, name of employer

_____

Name of Insurance Company

_____

Group number: _____ ID Number: _____

Insurance Company Telephone Number

(_____) _____-_____

*Please let us know if you have more than one dental insurance carrier.

FINANCIAL AGREEMENT:

While we try our best to accurately estimate your insurance benefits and co-payment, we cannot guarantee the final payment amounts, as they are decided by your insurance company. We collect your estimated co-payment at the time of service and then bill the insurance company for you. Your insurance company may take up to two months to process the claim and any portion not paid for by them is your responsibility. Please sign below to indicate you understand and agree to these conditions. Thank you.

X_____ _____/_____/_____

Patient Signature Date

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT

We now offer the following payment options:

___ Payment by cash

___ Payment by check

___ Payment by credit card

___ Bill my insurance, I will provide a credit card to guarantee any amount not covered.

Our office is a fully accredited user of the Visa and MasterCard Health Care Program which will enable you to use your Visa, MasterCard and Discover to automatically cover amounts not paid by your insurance.

*(Please circle one) Visa/MC/Discover/Amex #:*_____

Exp. Date: ____/____ *Security code: _____* *Billing zip code:*_____

___ Payment by CareCredit

*Account #*_____

CareCredit offers special financing and low monthly payment options, no up-front-costs, and no-prepayment penalties so you can start treatment at your time of need. We offer 6 or 12 month interest free plans at our office. Please ask the office manager for an application.

Appointment cancellation disclaimer

If you are unable to keep your appointment, please inform us as soon as possible via phone or e-mail. Appointments for treatment which are cancelled with less than 24 hours notice will incur a $120.00 charge.

I understand that a $120 broken appointment charge will be assessed to my account should I cancel within 24 hours of my scheduled appointment.

Please make your choice, sign below and return to the office manager before treatment.

Signature _____ Print name _____

Date: ____/____/_____

INFORMED CONSENT

We are concerned not only about your dental health and endodontic treatment needs, but also about your right as a patient to make the treatment decision that you feel is best for you. Our commitment to you is to provide you with detailed and complete information about your dental needs as we diagnose them. We will share our diagnostic processes with you, and we invite and welcome all of your questions regarding our work with you.

Towards this aim of a full, mutual sharing of information we feel it is important to advise you of the reasonably foreseeable risks of endodontic therapy. The following is important information you need to have in making your decision about treatment:

- Root canal therapy is a procedure designed to retain a tooth which may otherwise require extraction. Root canal therapy has a very high degree of success. However, it is a biological procedure and results cannot be guaranteed.

- Occasionally, and despite our best efforts, a tooth that has undergone non-surgical root canal therapy may require re-treatment or root canal surgery.

- We make special efforts to preserve the crowns of teeth we treat, but despite our best efforts occasionally a porcelain crown may fracture and require a new restoration.

- Even after root canal therapy, approximately 5% of endodontically treated teeth may eventually require extraction.

- Final restoration (crown) of the tooth that has undergone root canal therapy is essential for retention of the tooth. A Final restoration should be completed **within 30 days of root canal therapy**. Final restorations are provided by your restorative dentist.

x_____ __ _____/_____/_____

Signature of Patient (or Parent) Date

Notice of Privacy Policy and Patient Acknowledgment

We are committed to providing you with quality care, including protecting the confidentiality of your personal, medical and treatment information. In response to that commitment and in accordance with new federal legislation, we would like to provide you with written notification regarding our office privacy policy and the necessary uses and disclosures of your information.

- We may use your information to provide you with treatment. In treating you for a specific condition, we may need to know if you have allergies or are taking any medication that could affect your treatment in our office, or could interfere with medications we may prescribe.

- We may use your information to provide you with quality care. We may need to review your treatment plan with authorized staff and provide information to other healthcare offices to ensure excellent communication with all of those involved in caring for you.

- We may use your information so that payment for treatment can be processed. Personal information, office visit dates, codes identifying treatment and diagnosis are required for accurate documentation and processing financial information for payment by you or your insurance company.

We may contact you to provide appointment reminders, information regarding your treatment, and to discuss financial information.

We will not, unless required by law, share your protected information with any other agencies without your written authorization.

Patient Acknowledgment

In accordance with federal legislation, I have read and received notice of this privacy policy and understand I do not have to give written permission for these uses of my protected information. I have the right to inspect and copy protected information, to receive confidential communications regarding protected information, to complain if I believe my privacy rights have been violated and to receive a copy of this Notice of Privacy Policy upon request.

x_____ _____/_____/_____

Signature of Patient (or parent) Date