Patient Registration Date: _____

Date of Birth: _____

Patient: _____ Social Security #_____
Last First M.I.

Address: _____

City, State, Zip_____

Home phone: _____ Business phone: _____ Cellular: _____

Parent's name if patient a minor: _____

Who referred you to this office? _____

Insurance

Subscriber's name _____ Relationship to patient _____

If other than patient: Subscriber's Date of Birth _____ Social Security # _____

Name of Insurance Company: _____ Ins. Phone _____

Subscriber's employer _____ Group/policy #_____

Please check appropriate box. Your answers are for our records only and will be considered confidential.

Yes	No		Yes	No	
☐	☐	Heart Disease _____	☐	☐	Stomach Ulcers / Reflux
☐	☐	Heart Murmur or MVP	☐	☐	Hepatitis or Liver Disease
☐	☐	Pacemaker	☐	☐	Diabetes
☐	☐	High Blood Pressure	☐	☐	Kidney Disease
☐	☐	Lung Condition _____	☐	☐	Joint Replacement
☐	☐	Cancer_____	☐	☐	Thyroid Problems
☐	☐	Stroke	☐	☐	HIV+
☐	☐	Sinus Problems	☐	☐	Substance Abuse
☐	☐	Epilepsy	☐	☐	Pregnant, Nursing

Other conditions not listed above? _____

Medications presently taking _____

Allergies to any drugs? (Please list) _____

Do you require premedication with antibiotics prior to every dental treatment? _____

Do you have any condition / concern that may be relevant to the doctor in reference to your treatment here?

_____

I certify that above medical information is correct

Signature of Patient or guardian (and date) _____

Signature of Doctor _____

ENDODONTIC CONSENT AND INFORMATION SHEET

Endodontics, or root canal therapy, is that specialty of dentistry devoted to the saving of teeth in which the pulp or nerves are affected. It is true that it is easier to extract a tooth than to save it, but the value of a natural tooth is irreplaceable. In addition, extraction and replacement is usually more expensive.

We would like our patients to be informed about the various procedures involved in endodontic therapy and have 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 conventional root canal therapy, or when needed, endodontic surgery. The following discusses possible risks that might occur from endodontic treatment, and other treatment choices.

RISKS: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections. These complications include: swelling; sensitivity; bleeding; pain; infection; numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, which is transient but on infrequent occasions may be permanent; reaction to injections; changes in occlusion (biting); jaw muscle cramps and spasms; temporomandibular (jaw) joint difficulty; loosening of teeth; referred pain to ear, neck or head; nausea; vomiting; allergic reactions; delayed healing; sinus perforations and treatment failure.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY: The risks include the possibility of instruments broken within 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 canal; cracked teeth. During treatment complications may be discovered which make treatment impossible, or which may require dental surgery or extraction. These complications may include: blocked canals due to fillings or prior treatment; natural calcifications; broken instruments; curved roots; periodontal problems (gum disease); resorptive defects; splits of fractures of the teeth.

MEDICATIONS: Prescribed pain reliever medications and 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 effects. Antibiotics prescribed may impact the effectiveness of birth control medications. Allergic reactions to any and all medications are a risk which can cause from mild reactions to life-threatening effects.

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

OFFICE POILICY REGARDING INSURANCE: Our professional services are rendered and charged to you, not the insurance company. However, if insurance information is given to the receptionist prior to treatment and verification of benefits can be made, we will accept assignment of the insurance benefits. It is the patient's responsibility to pay the estimated portion of the fee not covered by the insurance upon completion of treatment. Accident cases or other benefit plans require prior approval.

CONSENT: I, the undersigned, being the patient (parent or guardian of minor patient) consent to the performing of 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, such as a crown, cap, or filling.

I understand that root canal treatment is an attempt to save a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery or even extraction.

Patient / Parent Signature Date