Northshore Endodontics

Charles O. Roy, DDS

PATIENT INFORMATION

❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. ❑ Dr.

Name	
Spouse/Partner	
Address	
City	State Zip Code
Home Phone	Work Phone
Cell Phone	Email Address
Social Security #	Birthdate
Employer	
If patient is a minor, parent or guardian	
In case of emergency, call	Phone(s)
Your regular (general) dentist	Phone
Your physician	Phone

INSURANCE INFORMATION

PRIMARY INSURANCE

❑ Self ❑ Spouse ❑ Parent ❑ Other

Insurance Company	
Group Code	

COMPLETE *(if not yourself)*

Employer	
Employee	
Social Security #	Birthdate

Please list below any medication you are presently taking:

Name	For

Which method of payment will you be using today? (Fees must be paid in full at time of service) ❑ CASH ❑ CHECK ❑ VISA ❑ MC ❑ DISCOVER ❑ AM EX ❑ CARE CREDIT

MEDICAL HISTORY (Confidential)

	YES	NO
Are you in good health?	❑	❑
Are you currently under the care of a physician?	❑	❑
For what condition?		
Have you ever experience any unusual complications following dental treatment?	❑	❑
Have you ever had excessive bleeding requiring special treatment?	❑	❑
Do you have significant anxieties about dental treatment?	❑	❑
Have you ever had any allergic reaction or other adverse reaction to any medication or other substances?	❑	❑

If yes, please list:

WOMEN

Are you or might you be pregnant?	❑	❑
Months? _____		
Are you nursing an infant?	❑	❑
Are you taking oral contraceptives (birth control pills)? (If yes, be advised that if you take antibiotics, an alternative method of birth control must be used.)	❑	❑

Please indicate any of the following you have had:

- ❑ Heart condition
- ❑ High blood pressure
- ❑ Rheumatic fever
- ❑ Mitral Valve Prolapse
- ❑ Artificial heart valves
- ❑ Pacemaker
- ❑ Stroke
- ❑ Respiratory condition
- ❑ Asthma
- ❑ Tuberculosis
- ❑ Sinus problems
- ❑ Hayfever / allergy
- ❑ Ulcers / Colitis
- ❑ Cancer
- ❑ Liver condition
- ❑ Hepititis A/B/C
- ❑ Blood condition
- ❑ Diabetes
- ❑ Glaucoma
- ❑ Epilepsy / seizures
- ❑ HIV / AIDS
- ❑ Kidney condition
- ❑ Arthritis / Rheumatism
- ❑ Cortisone medications
- ❑ TMJ disorder
- ❑ Artificial joints
- ❑ Substance recovery
- ❑ Radiation treatment
- ❑ Thyroid problems
- ❑ Endocrine disorders

Have you had any other serious illness not listed?

FINANCIAL INFORMATION

- Payment is required at the time of service.
- If you have dental insurance, we will be happy to bill your insurance company as a convenience to you. You will be required to pay only your estimated co-payment at time of treatment.
- We accept cash, checks, debit cards, Visa, MasterCard, and Discover.
- We do not offer any type of financing or payment plans.
- Uncollected funds owed over 90 days will be sent to a collection agency.

INSURANCE INFORMATION

- Please understand that regardless of insurance, you are responsible for all fees incurred. Your insurance policy is a contract between you and your insurance company. We will be happy to assist you in all claims, but we cannot guarantee your coverage.
- We will do everything we can to accurately estimate your co-payment, but differences may occur.
- Many insurance companies pay claims based on their own "UCR" fee schedules which are arbitrarily low and do not represent actual specialty fees in our area. Thus, they may not cover as high a percentage of the actual fees.
- If there is any question about your coverage, we will try to over estimate your portion so we will not have to bother you with a bill later. Any overpayment will be promptly refunded.
- Please feel free to ask us about anything concerning your treatment or the fees involved. We are here to help you!

CONSENT AND INFORMATION FORM

Regarding Health History, Endodontic (Root Canal) Therapy, Premedication, Local Anesthetic and Medication

It is the belief of this office that you should be informed about the treatment and that you should give your consent before starting the treatment. Root canal treatment is done in order to save a tooth which would otherwise need to be removed. In general terms, root canal treatment is the procedure in which diseased tissue is removed from inside the tooth. The root canal is cleaned, sterilized, filled, and sealed to prevent further infection and/or loss of the tooth. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery or even extraction. Risks of treatment are of two kinds: those risks involved in dental procedures in general, and those risks specific to endodontic treatment.

PLEASE DO NOT BE ALARMED BY THE FOLLOWING INFORMATION. MOST COMPLICATIONS ARE QUITE RARE.

RISKS OF DENTAL PROCEDURES IN GENERAL: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedations, medicines, analgesics (pain killers), anesthetics and injections.

These complications include pain, infection, swelling, bleeding, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, thrombophlebitis (inflammation to a vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth or restorations in teeth, injury to other tissues, referred pain to the ear, neck and head, nausea, vomiting, allergic reactions, itching, bruises, delayed healing, sinus complications, and further surgery. Medications and drugs may cause drowsiness as well as lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, until recovered from their effects. Antibiotics may interfere with the effectiveness of birth control pills.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY: These risks include instruments broken within the root canals or in the bone surrounding the tooth, perforations 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, and cracked teeth. During treatment, complications may be discovered which make treatment impossible, or which may require dental surgery. These complications may include: blocked canals due to fillings, prior treatment, natural calcification, broken instruments, curved roots, periodontal disease (gum disease) or fractures of the teeth. Surgical complications may occur which include numbness of the lip and/or chronic sinus problems.

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

I understand that after endodontic therapy, my tooth will require an additional restoration (filling, onlay, crown, or bridge). I realize that should I neglect to return to my restorative (family) dentist for the proper restoration within 14 days that there is an increased risk of: 1) Failure of the endodontic therapy, 2) Fracture of the tooth and/or, 3) premature loss of the tooth.

I understand that teeth treated with endodontic therapy can still decay. As with other teeth, the proper dental care of these teeth consists of good home care, sensible diet, and periodic check-ups.

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 further understand and agree to the financial policies above.

Patient / Parent / Guardian _____ Date _____