



PATIENT INFORMATION AND HISTORY

Name: _____ Age _____ Birthdate _____
Last First Middle Initial Male Female

Address _____
Number Street City State Zip Code

Social Security _____ Email _____ Tel # () _____

Occupation _____ Employer _____ Bus. Tel # () _____

Referred By _____ Dentist _____ Physician _____

SPOUSE, PARENT, OR OTHER GUARANTOR INFORMATION IF DIFFERENT THAN ABOVE

Who will be responsible for your account? Spouse Father Mother Other

Name _____ Birthdate _____ SS# _____

Address _____ Tel # () _____

Employer _____ SS# _____ Bus. Tel # () _____

PRIMARY DENTAL INSURANCE:

Policy Holder _____ SS# _____ Birthdate _____

Dental Company _____ Group # _____

Member ID # _____

SECONDARY DENTAL INSURANCE:

Policy Holder _____ SS# _____ Birthdate _____

Dental Company _____ Group # _____

Member ID # _____

Weight _____ Height _____

1. Are you under any medical treatment now? Yes No
2. Are you taking any drugs or any medication now? Yes No If Yes _____
-
3. Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If Yes _____
4. Have you had any major operations recently? Yes No If Yes _____
5. Have you ever had any joint or valve replacements in the past 2 years? Yes No
6. Have you or your relatives had a bad reaction to anesthesia? Yes No
7. Have you ever had an adverse reaction to any of the following? Asprin Penicillin Codeine Acrylic Local Anesthetics
 Metal Latex Sulfa Drugs No Other _____

8. Have you ever had a serious accident involving head or neck injuries? Yes No If Yes _____

9. Please check any of the following that apply to you:

- | | | | | |
|---|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Cold Sores/Canker Sores | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Cortisone Medication | <input type="checkbox"/> Hepatitis A or E | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Pain in Jaw Joints/TMJ | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Psychiatric Disorder | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack/Failure | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Venereal Diseases |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Shingles | |

10. Do you/did you abuse alcohol or drugs? Yes No
11. Do you have a severe gag reflex? Yes No
12. Have you had any abnormal oral bleeding? Yes No
13. Do you smoke or use tobacco? Yes No Quit: _____
14. (Female) Are you or could you be pregnant? Yes No Nursing? Yes No Oral Contraceptive? Yes No
15. Have you ever had any serious illness not listed? Yes No If Yes _____

Authorize

Privacy Practice Notice

I hereby acknowledge that a copy of Green Bay Endodontic's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask questions I may have regarding this Notice.

Patient/Parent (Guardian) Initials: _____

Authorization to Release All information to: _____ Relationship: _____

I understand that by initialing below I am confirming the use and disclosure of my protected health information to the authorized person(s) listed above. Authorization is good until I choose to revoke it.

Patient/Parent (Guardian) Initials: _____

DECLINE RELEASE OF MY INFORMATION

I hereby confirm that the above facts are true to the best of my knowledge. I will not hold my doctor or any other member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

Signature _____ Date _____



RESPONSIBILITY FOR PAYMENT

PATIENT NAME: _____

I agree to be and am fully responsible for total payment of services performed including any amounts not covered by any dental insurance, I may have.

I understand that the parent who requests treatment and/or presents a minor child for treatment is responsible for all fees for services rendered. In case of divorce, any arrangements made through a divorce agreement are strictly between the parents and do not involve the clinic.

I understand that clinic bills are due at the time of service regardless of any insurance coverage. I understand I am responsible for any NSF service charges as well as bank charges incurred. Insurance is designed to reimburse the policy-holder and is a contract between the policyholder and the insurance company. The clinic will do all it can to help collect legitimate claims. In the event the insurance company is slow to pay; reduces payment because in their estimation the charges are over usual and customary; or for some reason disallows the claim, I understand payment of the account is my responsibility.

(IF INSURED) I authorize the release of information including records and x-rays requested by my insurance company for the purpose of determining pre-treatment estimates, precertification or payment of insurance benefits. A copy of this authorization shall be as valid as the original.

Signature of Patient or Parent/Guardian Requesting Care

Date

If guardian responsible for payment is other than parent:

Name: _____

Relationship: _____

Address: _____

Phone:() _____



Authorization and Consent for Endodontics Procedure

I, _____, have been advised by my referring dentist that I require root canal treatment on tooth # _____ and I request and authorize Dr. Andrew Lulloff or Dr. Daniel McHenry to perform the root canal.

I understand that the root canal treatment is an attempt to save my tooth due to loss of vitality from infection, decay, crack, or to obtain sufficient retention for resorption. The alternative to root canal treatment is extraction.

I have discussed the root canal procedure with my dentist and I understand that the following risks and complications may arise.

1. Root canal treatment requires anesthesia and multiple radiographs (x-rays).
2. Local anesthesia injection sometimes causes trismus (difficulty in jaw opening) or paresthesia (temporary or permanent loss of sensation).
3. Postoperative discomfort or swelling, lasting a few hours to several days for which medications will be prescribed if deemed necessary by the dentist.
4. Allergic reactions to medication or anesthetics.
5. Separation of root canal instruments during treatment which may, in judgment of the dentist, be left in the treated root canal or require surgical procedure for removal.
6. Perforation of the root canal due to curved roots or existing conditions. This may require additional surgical treatment or extraction.
7. Premature tooth loss may result from cracks or fractures that can occur during the root canal treatment or from progressive periodontal gum disease.
8. Access through a crown or bridge (existing restorations) may result in damage to restorations, which is not the responsibility of this office.
9. Treatment may be discontinued due to calcified canals, separation of root canal instruments or reamers, or fracture of root or crown.
10. Success rate of root canal treatment is approximately 93%. (If failure occurs, the treatment may have to be redone, surgerized, or extracted.)
11. Post-surgical complications include: discomfort and pain, swelling, bruises, excessive bleeding, trismus, and injury to the nerve underlying the teeth which may result in numbness or tingling of the lip, chin, gums, or tongue on the operated side. This may persist for several weeks, months, or in remote instances, permanently. Also, there may be exposure of the sinus in the upper teeth.
12. The crown of the tooth may darken eventually and/or become brittle due to loss of vitality. We recommend placement of a crown or any other proper restoration determined by your referring dentist as soon as possible.

I understand that at any time during treatment, common medications may be prescribed that may have side effects such as nausea and diarrhea. If any adverse side effects such as itching, rash or hives occur, I am to stop the medication and call the dentist who prescribed them.

I understand that failure to continue with initiated treatment may result in the eventual loss of the tooth through decay, fracture, or extraction. If this occurs, I cannot hold the dentist who initiated the treatment responsible.

I understand that doing root canal therapy through crowns may hide existing decay or cracks, that are not visible to the dentist, and therefore, I cannot hold the dentist responsible for missing them.

I understand that after my root canal treatment is completed I should continue my treatment by placing a proper restoration on the tooth.

The undersigned certifies that he/she has read and is willing to comply with the foregoing, and is the patient, the parent with authority to give consent, or guardian of the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Date _____ Signed Name _____

