WELCOME!

LaSalle County Endodontics

Please complete the front and back. Please print. If you have questions, we are happy to help!

ABOUT YOU

Name _____ Date _____

Nickname _____ Phone _____

Birthdate _____ ❑ Male ❑ Female SS# _____

Address _____

City _____ State _____ Zip _____

Your employer _____ Occupation _____

Person responsible for this account _____

MEDICAL HISTORY

My General Dentist's name _____

My Physician's name _____ Phone _____

Do you smoke or use tobacco? ❑ Yes ❑ No Women: Are you Pregnant? ❑ Yes ❑ No Week # _____

Have you had any of the following medical conditions? *(Check all that apply)*

❑ Abnormal Bleeding
❑ Anxiety/Panic Disorder
❑ Arthritis
❑ Asthma
❑ Depression
❑ Diabetes/High Sugar
❑ Drug/Alcohol Abuse
❑ Endocarditis
❑ Epilepsy/Seizure
❑ Heart Attack/Stroke
❑ Heart Disease
❑ Heart Surgery
❑ Hepatitis
❑ High Blood Pressure
❑ HIV/AIDS
❑ Joint Replacements
❑ Pacemaker
❑ Psychiatric Problems
❑ Thyroid
❑ Tuberculosis

❑ Autoimmune Disease *(ex. Lupus, Rheumatoid Arthritis)* _____

❑ Cancer If Yes, Dates _____ Type _____

Medical Conditions *(Not listed above)* _____

_____

_____

_____

Are you allergic to: Penicillin ❑ Yes ❑ No Bleach ❑ Yes ❑ No Dental Anesthetics ❑ Yes ❑ No

Any other allergies? _____

List all medications you are currently taking _____

_____

_____

_____

_____

_____

In the event of an emergency, contact: Name _____ Phone _____

Are you <u>extremely</u> nervous about your dental visit? ❑ Yes ❑ No

Who referred you? _____

DENTAL INSURANCE

PRIMARY Dental Insurance:

Policy Holder _____

Ins. Co. Name _____

Group Number _____

ID or SS # _____

Birthdate _____

SECONDARY Dental Insurance:

Policy Holder _____

Ins. Co. Name _____

Group Number _____

ID or SS # _____

Birthdate _____

_____ *Initials* I authorize my insurance carrier *(if applicable)* to issue the dental benefits of my plan directly to this dental office. I also authorize release of any information necessary to process dental insurance.

INFORMED CONSENT FOR ENDODONTIC THERAPY

_____ *Initials* I hereby consent to all necessary diagnostic procedures *(including x-rays)* to determine if endodontic *(root canal)* therapy is indicated. If I choose treatment, I authorize the use of all appropriate medications, anesthetics, and additional services. I understand risks are involved.

_____ *Initials* I understand possible alternative methods of treatment are surgical endodontic procedures, tooth removal, or no treatment at all. If any of these options remain unclear to me I will ask Dr. Henry for an explanation of available options. I understand that I may also choose to decline treatment at any time before the procedure.

_____ *Initials* I understand approximately 95% of routine root canals are successful, however, success is not guaranteed. Failure of the endodontic treatment may require extraction of the tooth or a surgical root canal *(apicoectomy)*. An additional charge may be involved in both cases.

_____ *Initials* I understand treatment started in other offices or retreatment of prior root canals are usually not routine and may have a reduced overall prognosis.

_____ *Initials* I understand that after the root canal therapy, the tooth will need to be protected by a crown or in some cases a simple restoration *(filling)*. I will contact my general dentist soon after completion of the endodontic treatment if such care is needed to protect my root canal.

_____ *Initials* I understand that possible complications of treatment include, but are not limited to the following:

- Fractures or perforations of the crown or root of the tooth
- Swelling, fever, soreness, infection, hematoma, trismus *(limited jaw opening)*, nerve damage, altered sensation, or an allergic reaction that could result in heart attack, stroke, brain damage and/or death
- Additional unknown or unspecified problems, the explanation for and the responsibility of cannot be given or assumed
- Hospitalization or other emergency care may be required for any of the above

_____ *Initials* I will inform this office immediately if there is any change in my medical status.

_____ *Initials* I also acknowledge full responsibility for the payment of all services rendered and agree to pay them in full unless other specific arrangements have been made with the front desk coordinator. Accounts over 90 days past due are subject to a service charge.

SIGNATURE _____ DATE _____

UPDATED MEDICAL HISTORY AND CONSENT CONFIRMATION (Future Visits)

Initials_____ Date_____	Initials_____ Date_____	Initials_____ Date_____
Initials_____ Date_____	Initials_____ Date_____	Initials_____ Date_____

AMERICAN ASSOCIATION OF ENDODONTISTS
specialist member

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