☐ Dr.
☐ Mr.
☐ Mrs.
☐ Ms.
☐ Miss
☐ Fr.
☐ Rev.
☐ Sr.

PLEASE PRINT

DATE ______________________

PATIENT'S NAME ______________________ (LAST) ______________________ (FIRST) ______ (INITIAL) BIRTH DATE ______________

ADDRESS ____

CITY ______________________ STATE __________ ZIP __________ S.S. # ______________

HOME PHONE ______________________ CELL PHONE ______________________

EMPLOYER NAME ______________________________ WORK PHONE ______________

ADDRESS ______________________________ PHONE ______________

PARENT OR GUARDIAN NAME ______________________________ PHONE ______________

EMERGENCY CONTACT NAME / RELATIONSHIP ______________________________

DENTAL INSURANCE: YES_____ NO_____ PRIMARY ______________ SECONDARY ______________

IF THROUGH SPOUSE, PLEASE COMPLETE THE FOLLOWING:

NAME ______________ EMPLOYER ______________ BIRTH DATE ________ S.S.# ______________

INSURANCE NAME & ADDRESS ______________________________

REFERRED BY DR.: ______________________________

PLEASE STATE PROBLEM OR REASON FOR YOUR VISIT ______________________________

IS THE PRESENT PROBLEM DUE TO AN ACCIDENTAL INJURY YES_____ NO_____ DATE OF INJURY ______________

ANY TREATMENT DONE AT THE TIME OF INJURY? LIST ON HEALTH HISTORY PAGE. ______________

Endodontic Treatment (root canal therapy) is a procedure to retain a tooth which may otherwise require extraction. In general terms, endodontic treatment is the procedure in which diseased pulp tissue is removed from inside (endo) the tooth (odont). The root canal is cleaned, shaped, disinfected, and filled to seal the tooth and prevent further infection.

I, the undersigned, have been informed of the following facts about endodontic treatment:

1) Although endodontic treatment has a high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed.
2) Refusal of the recommended endodontic treatment will most likely result in:
   - Loss of tooth
   - Bone destruction due to an abscess
   - Possible systemic infection. (an infection affecting the whole body)
3) Sometimes, a tooth does not heal following endodontic treatment (5-10%) The tooth may require further treatment which may include retreatment, surgery on the root, or extraction.
4) Very small instruments are used during endodontic treatment. Although rare, it is possible for an instrument to break during the procedure and become permanently lodged in the tooth. This could possibly interfere with healing.
5) It is possible that during the course of endodontic treatment, an instrument may perforate the root wall. Repair, surgery, or extraction may then be necessary.
6) When making an access (opening) through an existing crown or placing a rubber dam clamp, damage to the crown could occur; a new crown would be necessary.
7) Successful completion of endodontic treatment does not prevent future decay or fracture.
8) Temporary fillings are usually placed after endodontic treatment. Full restoration (usually a crown) should be completed by your general dentist as soon as possible. Delaying this restoration may result in loss of the temporary filling with possible reinfection or fracture of the tooth, possibly requiring extraction of the tooth.

There are risks involved in the administration of anesthetics, analgesics (pain medication), and antibiotics. I have informed the doctor of any previous side affects or allergies.

______________________________ Patient or Guardian's Signature

______________________________ Witness to Signature

OVER

	yes	no
Family Physician's Name ____________________ Phone __________		
Do you have any general health problems __________	☐	☐
Are you being treated by a physician now? __________	☐	☐
Do you pre-med for dental appointments? **(If so, why?)** __________	☐	☐
Have you had any prosthetic implants?(eg. hip, knee, valve) **(If yes, list surgery dates)** __________	☐	☐
Do you take any drugs or medication including oral birth control? **(If yes, please list below)** __________ Note: Antibiotics may prevent oral birth control from being effective.	☐	☐
Are you currently taking or have you previously taken bisphospomates such as Actonel, Fosmax or Zometa in the past 12 years? __________	☐	☐
Are you subject to slow healing or prolonged bleeding? __________	☐	☐
Do you have any allergies or hay fever? __________	☐	☐
Have you ever had any ill effect from penicillin, other antibiotics, aspirin, codeine, local anesthetics, household bleach, other medications, or latex rubber? __________	☐	☐
If female, are you pregnant? if yes, due date __________	☐	☐

Please CIRCLE any of the following conditions you have or have had and give details below:

Auto-Immune Disorder	Diabetes	Osteoporosis
AIDS / (HIV Status) Pos ☐ Neg ☐	Epilepsy / Seizures	Radiation Therapy
Anemia	Glaucoma	Rheumatic Fever
Arthritis	Heart Problems	Sinus Infection
Asthma	High or Low Blood Pressure	Surgery
Cancer	Kidney or Liver Involvement	Tuberculosis
Chemotherapy	Mitral Valve Prolapse / Heart Murmur	Ulcers / Reflux / GERD

If any of the above questions are answered yes or any conditions circled, please explain with dates, treatment received, etc.

Please list other health problems and all medications below.

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Patient, Parent or Guardian Signature ____________________ Date __________

NO INSURANCE COVERAGE

Payment in full is due at completion of treatment. Payment can be made in cash, check, Master Card, or Visa.

SIGNATURE____

INSURANCE COVERAGE

Since we deal with many insurance companies, we cannot be aware of the specific coverage, deductibles, co-insurance, fee schedules, and policies of each insurance. The options for insured patients are the following:

Please select your method of payment by signing one of the choices below.

INSURANCE REQUIRING DOWN PAYMENT

Upon completion of treatment; I will pay a deposit of 25% of the total fee. I assign the insurance benefits to Endodontic Associates LTD. After the insurance payment is received, Endodontic Associates LTD. will refund any credit or bill any unpaid balance to me. I authorize the release of any dental records needed for the submission of my claim.

SIGNATURE____

PATIENTS WITH DELTA DENTAL INSURANCE

Upon completion of treatment, I will pay a deposit of 20% of the total fee. I assign the insurance benefits to Endodontic Associates LTD. After the insurance payment is received, Endodontic Associates LTD. will refund any credit or bill any unpaid balance to me. I authorize the release of any dental records needed for the submission of my claim.

SIGNATURE____

PATIENTS WITH WISCONSIN HEALTH FUND

As of March of 2003 WHF has gone to a pay per service policy. They approximately pay half of our fee. Therefore, upon completion of treatment in our office 50% of our total would be due. I assign the insured benefits to Endodontic Associates, LTD. I authorize the release of any dental records needed for submission of my claim.

SIGNATURE____

PATIENTS WITH TWO INSURANCES

Upon completion of treatment, Endodontic Associates LTD will submit your dental treatment and cost to your primary coverage. Upon hearing from them, the remaining balance will be submitted to your secondary insurance. You will be billed and responsible for any remaining balance. I authorize the release of any dental records needed for the submission and processing of my claims.

SIGNATURE____

Thank You,

Endodontic Associates, LTD