PATIENT INFORMATION

Name : _____
Address : _____
City, State, Zip: _____

Home Phone #_____ Cell#_____
Work Phone #_____

SS#_____ Birthdate: _____
Spouse's Name: _____ Cell# _____
Emergency Contact : Name:_____ Cell#_____

Physician: _____ Phone: _____
Dentist: _____ Phone: _____
If not referred by dentist, who referred you?_____
Pharmacy:_____ Phone:_____

Who is financially responsible for this bill?_____
Address_____Phone_____
Dental Insurance: _____
Occupation_____
Employer: _____
Employer's Address: _____

Payments must be made BEFORE services are completed.
Paying by Cash _____ Check _____ Credit Card _____

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. My insurance was contacted by the first day of treatment to calculate an estimated out of pocket expense. If there are any outstanding claims, submitted by other dentists, my benefits may be reduced and I will be liable for the balance due. I also understand that only the root canal is to be completed at this office. The permanent restoration will be completed by me regular dentist.

_____ Date_____
Signature

_____ Date_____
Parent (if minor)

MEDICAL HISTORY

Name:_____ **Date:**_____

Circle

1. **Are you having pain or discomfort at this time?.....Yes No**
2. **Do you feel very nervous about having dentistry treatment?..... Yes No**
3. **Have you ever had a bad experience in the dentist's office?.....Yes No**
4. **Have you been a patient in the hospital during the past two years?.....Yes No**
5. **Have you been under the care of a medical doctor during the past two years?.....Yes No**
6. **List any prescribed or over-the-counter medicines you are presently taking:**

   _____

   _____
7. **Are you allergic to or made sick by penicillin, aspirin, sulfa, codeine, latex , or any other drugs or medications? If so, which ones?.....Yes No**
8. **Have you ever had any excessive bleeding requiring special treatment?.....Yes No**
9. **Circle any of the following which you have had or have at present:**

Heart Failure	**Emphysema**	**Depressed Immune System**
Heart Disease or Attack	**Cough**	**Hepatitis A (Infectious)**
Angina Pectoris	**Tuberculosis (TB)**	**Hepatitis B (Serum)**
High Blood Pressure	**Asthma**	**Liver Disease**
Heart Murmur	**Hay Fever**	**Yellow Jaundice**
Mitral Valve Prolapse	**Sinus Trouble**	**Blood Transfusion**
Rheumatic Fever	**Hives**	**Drug Addiction**
Congenital Heart Lesions	**Diabetes**	**Hemophilia**
Scarlet Fever	**Thyroid Disease**	**Venereal Disease**
Artificial Heart Valve	**X-ray/Cobalt Treatment**	**Cold Sores**
Heart Pacemaker	**Chemotherapy**	**Genital Herpes**
Heart Surgery	**(Cancer, Leukemia)**	**Epilepsy or Seizures**
Anemia	**Arthritis**	**Fainting or Dizzy Spells**
Stroke	**Rheumatism**	**Psychiatric Treatment**
Kidney Trouble	**Glaucoma**	**Nervousness**
Ulcers	**Cortisone Medicine**	**Sickle Cell Disease**
Pain in Jaw Joints	**Bruise Easily**	**Artificial Joint**

OVER ...

Circle

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath or because you are very tired?..... Yes No

11. Do your ankles swell during the day?..... Yes No

12. Do you use more that two pillows to sleep?..... Yes No

13. Have you lost or gained more than ten pounds in the past year?..... Yes No

14. Do you ever wake up from sleep short of breath?..... Yes No

15. Are you on a special diet?..... Yes No

16. Has your medical doctor ever said you have cancer or a tumor?..... Yes No

17. Do you have any disease, condition or problem not listed? Please explain..... Yes No

18. WOMEN: Are you pregnant?..... Yes No
Are you practicing birth control?..... Yes No
Do you anticipate becoming pregnant?..... Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the dentist at the next appointment without fail.

_____
Signature of Patient, Parent, Guardian

I authorize release of any information relating to this claim regarding my dental history, treatment, etc. to any insurance company, physician, dentist or organization.

_____
Signature Date

Medical History Update

_____ _____
Date Addition

_____ _____
Date Addition

GRAZIANO & TAGOURI, LLP
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Authorization and Informed Consent for Endodontic Therapy

Patient's Name_____

I hereby authorize the endodontist and whomever he may designate as his assistant(s) to perform the following endodontic procedure on tooth #_____ to treat my dental problem or condition: _____Root canal therapy, _____ Pulpotomy/ectomy, _____Apexification, _____Incision & Drainage, _____Other. I further authorize the administration of medications and anesthetics, performance of diagnostic procedures and such additional service that may be deemed reasonable and necessary, understanding that risks are involved. The reason for and the nature of these procedures have been explained to me.

Estimate _____

Possible alternative methods of treatment may include the following: _____surgical procedures, _____tooth removal, _____other, and the advantages or disadvantages of each have been discussed. I have been advised that I may also choose to decline treatment at this time and understand the risks in not having treatment include, but are not limited to, pain, swelling, infection, increased bone loss or loss of the tooth.

I also understand the following:

1. As a rule, 90-95% of routine cases are successful. Endodontics, as with any branch of medicine or dentistry, is not an exact science. Therefore, no guarantee of treatment success can be given or implied. If the case is not successful, the treatment may have to be redone, a surgical procedure required or the tooth extracted.

2. Cases started in other offices or retreatment cases are usually more difficult and may have a different outcome than expected under optimal conditions.

3. Calcification in one or more of the canals can alter the prognosis of the procedure. This does not change the root canal fee.

4. Inability to negotiate the full length of the canal(s).

5. Proper post-treatment restoration (filling, onlay, crown, etc.) is a necessity. I must contact my referring dentist soon after completion of the endodontics to arrange for this.

6. Periodic recall examination is recommended to evaluate the healing after treatment and no further charges are made for it. However, compliance is the responsibility of the patient.

7. It may be necessary to alter the tooth structure or remove the restoration of the tooth being treated.

8. Possible complications of treatment include, but are not limited to the following:

A. Procedural difficulties in the course of treatment.
B. Swelling, soreness, infection, trismus or discoloration of the adjacent soft or hard tissues.
C. Fractures of the crown or root of the tooth or restoration.
D. Fragmentation of root canal instruments during treatment.
E. Perforation of the root with instruments.
F. Complications following anesthesia (hematoma, temporary or permanent numbness, allergy, heart rate, etc.)
G. Additional unknown or unspecified problems, the explanation for and the responsibility of which cannot be given or assumed.

9. Some cases may need a supplemental 3D (Cone Beam CT) x-ray which may not be covered by your insurance. The fee is $ _____.

Treatment will be performed in accordance with accepted methods of clinical practice. Included in the therapy will be the taking of a minimal number of x-rays as dictated by the courses of treatment. We do our ultimate best to identify the possibility of a crack or fracture utilizing high magnification, microscope, and/or 3D scan. However, microscopic cracks may go unnoticed and propagate after treatment. If this does occur there is a chance the tooth may need to be extracted. Immediate definitive restoration is encouraged. Initial_____

If treatment is initiated but cannot be completed due to factors outside our control including but not limited to, inability to locate or treat canals, extensive cracks or fractures, and persistent infections, this is considered incomplete and a fee that you are responsible for is still assessed.
Initial_____

I have read and understand the above information. **Date**

_____
Signature of Endodontist

I acknowledge receipt of Notice of Privacy Practices.

_____
Signature **Date**