PRIME ENDODONTICS
YOUR ROOT CANAL SPECIALIST

Patient Information

The following is confidential information and for our records only.

Mr.
Mrs. Patient's Name____Birth Date__________
Ms. First Last Middle Initial

Home #____________________Work #____________________Cell #____________________

Email: ___

Home Address____
Street City State Zip Code

Patient's Social Security # ____________________ Employer______________Occupation______________

Referred By/General Dentist ______________________________________Phone #______________

Primary Subscriber for Insurance

Name____Birth Date__________
First Last Middle Initial

Social Security #_________________________Relationship to the patient:_________________________

Employer ____________________Occupation ______________How long have you been working there?________

Employer's Address____
Street City State Zip Code

Dental Insurance Information

Insurance Company_________________________ Insurance ID #_________________________

Do you have dual coverage? Yes___No___ If yes: Insurance Company_________________________

Primary Subscriber _________________________ Insurance ID# _________________________

Permission for Treatment and Responsibility for Payment

I, the undersigned, being the patient or guardian of the above minor patient, consent to the performing of whatever procedure may be decided to be necessary (x-Rays, Dx. Tests, Pictures…) or advisable in the opinion of the doctor, and to the administration of medications deemed indicated including local anesthesia, and antibiotics. **No treatment will be instituted until the doctor has explained and discussed treatment alternatives and consequences, and I have decided to begin the recommend treatment.**

I understand that root canal therapy is an attempt to retain a tooth which might otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had a root canal therapy may require retreatment, surgery, or even extraction. Present filling, inlays or crowns may need replacement after root canal therapy.

We reserve the right to charge for any appointments that are missed without 24 hours notice.

I understand that total payment of the fee for dental services performed by Prime Endodontics is my responsibility and not that of the insurance company. If your insurance policy has been expired prior to the date of treatment you will be responsible for our UCR fees. In the event payments are not received, I understand that a 1.5% finance charge (18% APR) may be added to my account in addition to any collection charges.

I certify that this information is accurate and by signing this document hold myself legally responsible.

Signature____ **Date**____________________
PARENT OR GUARDIAN IF PATIENT UNDER IS 18 YEARS OF AGE

MEDICAL HISTORY

In case of emergency contact: Name ___________________________ Relationship _________________ Phone______________________

PHARMACY AND PRIMARY PHYSICIAN____ Phone______________________

Please Check YES or NO

Date of last physical exam: _________________

		YES	NO
1.	Do you have any unhealed injuries, or inflamed areas, growths or sore spots in and around your mouth?	___	___
2.	Has there been a change in your general health within the past year?	___	___
3.	Are you under the care of a physician for a current problem? If yes, please explain: ____	___	___
4.	Have you been hospitalized in the past 5 years? If yes, please explain: ____	___	___
5.	Have you received therapy for alcoholism or drug addiction during the past 5 years?	___	___
6.	Have you ever had an **ADVERSE REACTION (allergic reaction)** to: PLEASE CIRCLE ALL THAT APPLY _ **PENICILLIN _NOVACAINE _ CODEINE _ASPRIN _LATEX _IODINE** any others: ________	___	___
7.	Is there a condition concerning your health the Doctor should know about? If yes, please explain____	___	___
8.	Have you had abnormal bleeding with previous extractions, surgery, or trauma?	___	___
9.	Do you or have you used *bisphosphonate* medication to prevent or treat osteoporosis or as part of a cancer treatment? (i.e. **Fosamax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa and Bonefos**)	___	___
10.	Have you ever had chemotherapy and/or radiation for a tumor, growth or other condition?	___	___
11.	Have you ever been tested positively for HIV infection or AIDS? If yes, date diagnosed and the treating Doctor's name: ___________________________________	___	___
12.	Are you required to pre-medicate/take an antibiotic prior to dental treatment (per medical Doctor)?	___	___
13.	Women ONLY---Are you pregnant, nursing or taking birth control pills? If yes, please specify ____	___	___

14. Do you have or had any of the following? Please check yes or no to ALL questions:

Yes	No		Yes	No	
___	___	High Blood Pressure	___	___	Sinus Trouble/Hay Fever
___	___	Heart Murmur or Prolapsed Valve	___	___	Thyroid Problems
___	___	Joint Prosthesis (hip, knee, etc.)	___	___	Diabetes
___	___	Rheumatic Fever or Rheumatic Heart Disease	___	___	Stomach Ulcer
___	___	Congenital Heart Disease	___	___	Hepatitis (A, B, C, or other?)
___	___	Cardiovascular Disease: heart attack, stroke or bypass	___	___	Kidney Problems
___	___	Prosthetic Heart Valve	___	___	Psychiatric Treatment
___	___	Blood Disorder (e.g. anemia)	___	___	Fainting Spells
___	___	Venereal Disease	___	___	Epilepsy
___	___	Asthma	___	___	jaundice, liver disease
___	___	Chest Pains, or Angina	___	___	Dialysis
___	___	Swollen Ankles	___	___	Cardiac Pacemaker
___	___	Heart Surgery	___	___	Chronic Bronchitis, Chronic Cough
___	___	Delay in Healing	___	___	Herpes/Cold Sores
___	___	Problems w/ Immune System	___	___	Fibromyalgia
___	___	Emphysema	___	___	Difficult Breathing or other Lung Trouble
___	___	Eye Disease or Glaucoma	___	___	Bruise easily
___	___	Temporomandibular Joint Problems (TMJ)	___	___	Ever taken "Fen Phen" Diet pill

15. Are you taking any Herbal Medications i.e. St. John Wart? If yes, please list. ____
16. Do you have any disease or condition not listed above? Please list.
____

17. Are you taking any medications or drug? Please list them and their uses below:

____

Signature______________________________________ **Date**________________ Staff Initials_______
PARENT OR GUARDIAN IF PATIENT IS UNDER 18 YEARS OF AGE

Medical History Update (for staff use only)

Changes ____ Date ___________________Initials________

Office Use Only

BP:
Pulse:
Date:
Staff:

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We have provided the "Dental Materials Fact Sheet" & "Notice of Privacy Practices" for your review in our reception area, if you would like to have your individual copy please let us know and one will be provided to you.

Patient Acknowledgment of receipt of Dental Materials Fact Sheet & Notice of Privacy Practices

A copy of the Dental Material Fact Sheet & Notice of Privacy Practices was provided to me by Prime Endodontics as required by law.

Patient Signature ____________________________
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Authorization for Signature on File

PATIENT- Release of Information/Financial Responsibility

I the above patient, hereby authorize this office to affix my name to any and all claims or documents as related to any and all health benefits to me and my dependents through my employment.
I certify that I am, my spouse is or my parent is currently employed with____
Employer Name

And that my dental benefits are active.

I hereby authorize payment of dental benefits otherwise payable to me, directly to the office listed above. This **"Signature on File"** will be valid from this date and a photocopy of this document may act as an original.

____
Patient Signature
PARENT OR GUARDIAN IF PATIENT IS UNDER 18 YEARS OF AGE

Language Assistance Refusal Form

Patient's Primary Language: ___English ___Spanish Other: ______________________

Please Check One: ___ I can read, write and understand English. I do not require interpretive services
___ I prefer to use interpretive services provided by (check one)
___ Insurance Company ___Family or Friend (Must be over 18yrs old.)

The treatment plan, treatment options, risks, benefits, prognosis, alternative treatment options, risks of delaying or no treatment and financial obligations were explained to me in my primary language of: ____

This form was explained to me in my primary language by:____
(Name of Interpreter)

_________________________	_________________________
Print Patient Name	Print Name of Interpreter
Patient Signature PARENT OR GUARDIAN IF PATIENT IS UNDER 18 YEARS OF AGE	Signature of Interpreter
Date	Staff Initials

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Endodontic Informed Consent

I understand that root canal treatment is an attempt to save my tooth due to loss of vitality from infections, decay, crack or to obtain sufficient retention for restoration. The alternative to root canal treatment is extraction.
I have discussed the root canal procedure with Dr. Lazar and his staff, 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. Post-operative discomfort or swelling, lasting a few hours to several days, for which medication will be prescribed if deemed necessary by the dentist.
4. Allergic reactions to the medication or anesthetics
5. Separations 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 of fractures that can occur during the root canal treatment or from progressive periodontal gum disease.
8. Treatment may be discontinued due to calcified canals, separation of root canal instruments or reamers, or fractures of root or crown.
9. Access through a crown or bridge (existing restorations) may result in damage to restorations, which is not the responsibility of the dentist
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 complication includes 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 the 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 during root canal therapy through crowns may hide existing decay or cracks that are not visible to the dentist, and therefore cannot hold the dentist who initiated the treatment responsible.

I understand that upon completion of root canal therapy in this office, I am to return to my regular dentist for any necessary permanent restoration.

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.

Signature____ **Staff and /or Doctor Signature** ______________________________
PARENT OR GUARDIAN IF PATIENT IS UNDER 18 YEARS OF AGE