Endodontic Associates

Medical History – Please answer each question.

Patient Name (please print):_____

Are you taking medication for any of the following:

1. Heart Rate:	O Yes O No	13. Pain Medications:	O Yes O No
2. Blood Pressure:	O Yes O No	14. Antibiotics:	O Yes O No
3. Blood Thinner:	O Yes O No	15. Arthritis:	O Yes O No
4. Cholesterol:	O Yes O No	16. Asthma/Breathing:	O Yes O No
5. Diabetes:	O Yes O No	17. Thyroid:	O Yes O No
6. Migraines:	O Yes O No	18. Seizures:	O Yes O No
7. Chemotherapy:	O Yes O No	19. Birth Control:	O Yes O No
8. Anti-depressant:	O Yes O No	20. Hormones:	O Yes O No
9. Anti-anxiety	O Yes O No	21. Osteoporosis:	O Yes O No
11. Sleep Aids	O Yes O No	Other:_____	
12. Herbal Medications	O Yes O No	_____	

Do you or have you had any of the following:

1. Diabetes:	O Yes O No	10. Cancer:	O Yes O No
2. Hepatitis A,B,C,D:	O Yes O No	12. Stroke:	O Yes O No
3. Thrush:	O Yes O No	13. Artificial Joint:	O Yes O No
4. Herpes:	O Yes O No	14. Tuberculosis:	O Yes O No
5. Thyroid Problems:	O Yes O No	15. AIDS/HIV:	O Yes O No
6. Pacemaker:	O Yes O No	16. Chest Pain:	O Yes O No
7. Heart murmur:	O Yes O No	17. Mitral Valve Prolapse:	O Yes O No
8. Heart attack:	O Yes O No	18. High Blood Pressure:	O Yes O No
9. Ulcer/Stomach:	O Yes O No		

Are you allergic to any of the following:

1. Penicillin:	O Yes O No	5. Codeine:	O Yes O No
2. Aspirin:	O Yes O No	6. Dental Anesthesia:	O Yes O No
3. Demerol:	O Yes O No	7. Latex:	O Yes O No
4. Sulfa Drugs:	O Yes O No	8. Other: _____	

Do you **pre-medicate** with antibiotics prior to dental treatment for an artificial joint or artificial heart valve? O Yes O No

Are there any other conditions you feel are important? O Yes O No

_____

_____

Signature of Patient or Guardian _____ Date _____

Pharmacy Information

Preferred Pharmacy Name:_____

Pharmacy Address:_____

Pharmacy Phone #:_____

HIPAA acknowledgement and Medical Release

I, _____ authorize

Patient Name

Endodontic Associates, P.A.

to **release** my dental records and billing/account history to:

Name:_____

Relationship:_____

Address:_____

_____

Home phone:_____

Mobile phone:_____

Email:_____

Name:_____

Relationship:_____

Address:_____

_____

Home phone:_____

Mobile phone:_____

Email:_____

Patient Signature:_____ **Date :**_____

Endodontic
ASSOCIATES, P.A.

Cool Springs Office: 8112 Isabella Lane, Suite 105, Brentwood, TN 37027 * Telephone 615.371.9559
Hill Center at Green Hills Office: 4027 Hillsboro Pike, Suite 805, Nashville TN 37215 * Telephone 615.383.4455
Thompson Station Office: 4720 Traders Way, Suite 1100, Thompson Station, TN 37179 * Telephone 615.721.3720

Endodontic Associates

INFORMATION AND CONSENT

Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to be removed. The following are possible risks that may occur with endodontic treatment.

GENERAL RISKS OF DENTAL CARE:

Included (but not limited to) are complications resulting from the use of dental instruments and medicines such as antibiotics, analgesics (pain killers), and local anesthetic injections. These complications may include swelling; bruising; sensitivity; bleeding; pain; infection; **numbness and tingling sensation in the lip; tongue; chin; gums; cheeks; and teeth; which is usually temporary but may be permanent;** reaction to injections; changes in biting; jaw muscle cramps and spasms; joint difficulty; loosening of teeth; referred pain to ear, neck and head; nausea; vomiting; allergic reactions; delayed healing; sinus perforations and treatment failure.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY:

The risks include the possibility of instruments broken within the root canals; perforations (extra openings) of the crown or root; damage to bridges; existing fillings; damage to crowns or porcelain veneers; loss of tooth structure in gaining access to canals; and cracked teeth. During treatment, complications may be discovered which may include: blocked canals due to filling prior to treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), splits or fractures of the teeth.

MEDICATIONS:

Some prescribed medications and drugs may cause drowsiness, lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs). Women who are taking birth control pills and are given a prescription for an antibiotic are strongly advised to use additional means of birth control during the entire monthly cycle. If you are using any prescribed or over the counter drugs, please inform the doctor prior to any treatment. Complications following local anesthetic can include: bruising, paresthesia, rapid heart rate, fainting or allergic reaction.

OTHER TREATMENT CHOICES:

These include no treatment, waiting for more definitive symptoms, tooth extraction and subsequent implant option. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and spread of infection to other areas.

OVER→

Endodontic
ASSOCIATES, P.A.

CONSENT:

I (parent or guardian of minor patient) consent to the performing of procedures necessary or advisable in the opinion of the doctor. I also understand that upon completion of root canal therapy, I shall return to my family dentist for a final restoration of the tooth treated (crown or filling).

I understand that root canal treatment is an attempt to save a tooth, which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth, which has had root canal therapy, may require retreatment, corrective surgery or extraction, which will incur an additional fee.

HIPAA:

I acknowledge that this office's notice of privacy practices is available to me and is posted in the lobby.

INSURANCE/FINANCIAL:

I authorize the release of any information relating to all claims and hereby direct benefits payable to Endodontic Associates. My co-payment is due at initiation of treatment. Any balance not paid by insurance is my responsibility. I understand that this office will accept an insurance benefit payment with the patient's portion being due at the time of service. I understand insurance co-payment quoted at time of service is only an estimate and there may be a balance remaining after dental insurance payment. I also understand that I am fully responsible for the entire balance for the services rendered after actual insurance benefits are paid.

INCOMPLETE TREATMENT:

If the doctor determines during the procedure that the tooth is non-restorable, there may be a fee of $370 for incomplete treatment.

MEDICAL INSURANCE:

Endodontic Associates does not file workman's comp, medical or accident insurance. Endodontic Associates will provide all documentation needed to file a claim.

If you have any questions regarding the procedures, medications, or costs involved please ask prior to the start of treatment. I hereby state that I have read and understood this consent.

Patient Signature _____

Date _____