Patient Information

Legal Name _____ Preferred Name _____
First Mid. Initial Last

Mailing Address _____
Street/P.O. Box Unit City State Zip

Cell Phone_____ Home Phone_____ Email_____

Date of Birth_____ Social Security #_____

Check appropriate: Single____ Married____ Divorced____ Separated____ Widowed____ Domestic Partner____

Whom may we thank for referring you? _____

In case of emergency who should be notified? Name_____ Phone_____

HIPAA Acknowledgement of Receipt of Notice of Privacy Practices

Please print name_____ Signature_____ Date_____

You may refuse to sign this acknowledgement _____ Patient refused to sign HIPAA

Release of Information

I hereby give permission to the person(s) listed below to receive information about the case of the above-named patient.

Name_____ Relationship to patient_____ Treatment____ Financial ____

CHECK ALL THAT APPLY

Method of Payment

Your estimated portion is due at the completion of treatment.

Methods of payment you will be using. __Cash __Check __VISA __ MC __ Discover ___Care Credit Last 4 digits_____

MY POTENTIAL FEES:	**OUR FEE**	**YOUR EST. PORTION**
Consultation	$108.	$_____
3D Scan (if taken)	$_____	$_____
Root Canal Treatment _____	$_____	$_____
Root Canal Re-treatment _____	$_____	$_____
Incomplete Root Canal Treatment due to non-restorable tooth	$591.	$_____
GentleWave Materials Fee (when used**)	$120.	$120.
Other_____	$_____	$_____
Discount _____	$_____	$_____

IF DENTAL INSURANCE APPLIES: After my insurance pays its portion, I will be notified of any remaining balance or refund due and understand that my original form of payment will be used. Although this office files insurance claims as a service to the patient, the insurance contract is between the patient and the insurance company. As we have no control over the insurance company's amount of payment, any difference of payment is entirely the responsibility of the patient.

Initials_____

Permission for Consultation/Root Canal Treatment

I, the undersigned, consent to a consultation and/or the performing of any dental procedure of the tooth (teeth) which, in the opinion of the doctor, is considered necessary or advisable. I also understand my other option is extraction. I also understand that only the root canal treatment is to be done at the office. The permanent restoration (outside filling, inlay, crown etc.) will be completed by my regular dentist.

Signature_____ **Date**_____

Medical History

Please complete each question

The information you provide is for our records and will be considered strictly confidential. In addition, it is your responsibility to update this medical history when any changes occur.

1. List any medications you are currently taking:
   Medication:_____Being taken for: _____
   Medication:_____Being taken for: _____
   Medication:_____Being taken for: _____
   Medication:_____Being taken for: _____
   Medication:_____Being taken for: _____
   Medication:_____Being taken for: _____
2. Are you taking or scheduled to begin taking either of these medications?
   Alendronate (Fosamax®) or Risedronate (Actonel®) for osteoporosis or Paget's disease? ..... **Yes** **No**
3. Have you ever had any **ALLERGIC or ADVERSE REACTIONS to anesthetics**, antibiotics, or other medications? Please explain and the reaction it causes: _____ **Yes** **No**
4. Have you ever had an **ALLERGIC or ADVERSE REACTION to LATEX**? Reaction:_____ **Yes** **No**
5. Are you required to take premeds prior to dental treatment? WHY?_____ **Yes** **No**
6. Are you currently under your medical doctor's care for a current medical problem? ..... **Yes** **No**
   Reason:_____
7. Have you been hospitalized in the past five years? ..... **Yes** **No**
   Reason: _____
8. Have you received therapy for alcoholism or drug addiction during the past five years? ..... **Yes** **No**
9. Have you ever required a blood transfusion? Please explain:_____ **Yes** **No**
10. Have you ever had surgery and/or radiation for a tumor, growth, or other condition? ..... **Yes** **No**
11. Do you smoke, snuff, chew, or use canabis?..... **Yes** **No**
12. **Do you or have you ever had any of the following (please check):**

____ Joint replacement Pre-Med? **Y / N**
____ Angina pectoris
____ Thyroid problems
____ Asthma Controlled? **Y / N**
Last Albuterol _____
____ Hepatitis-Type:____
____ Difficult breathing
____ Frequent headaches
____ Emphysema
____ Lung disease
____ Psychiatric problems
____ Diabetes
Last BG Level _____
Controlled? **Y / N**
____ Blood disorders:
____ Sickle cell disease
____ Anemia
____ Abnormal bleeding

____ High blood pressure- Controlled? **Y / N**
____ Active tuberculosis
____ Venereal diseases
____ Stroke Controlled? **Y / N**
Last episode_____
____ Cancer/chemotherapy
____ Fever blisters
____ Sinus problems
____ Liver disease
____ HIV/AIDS
____ Kidney problems
____ Seizures
Last episode_____
Controlled? **Y / N**
____ Heart Conditions: Pre-Med? **Y / N** Controlled? **Y / N**
____ Heart murmur of prolapsed valve MVP
____ Pacemaker
____ Artificial heart valves
____ Congenital heart defect

Women Only

Pregnant? Yes / No If yes, number of weeks? _____Nursing? **Yes /No**

All The Above Information Is True and Complete

Signature_____ **Date**_____