## Minor Information

Name ____________________________________________ Preferred Name ____________________
First Mid. Initial Last
Date of Birth____________________ Who may we thank for referring you?________________________________

## Accompanying Parent/Guardian

Name ____________________________________________ Preferred Name ____________________
First Mid. Initial Last
Relationship to Patient______________________________ Date of Birth______________________ Emergency Contact? Yes No
Mailing Address__________________________________________________________________
Street/P.O. Box Unit # City State Zip
Cell Phone____________________ Home Phone____________________ Email________________________________
S.S. #________________________________________ Check appropriate space: Single___ Married___ Divorced___ Separated___

## Financially Responsible (if different)

Name ____________________________________________ Preferred Name ____________________
First Mid. Initial Last
Relationship to Patient______________________________ Date of Birth______________________ Emergency Contact? Yes No
Mailing Address__________________________________________________________________
Street/P.O. Box Unit # City State Zip
Cell Phone____________________ Home Phone____________________ Email________________________________
S.S. #________________________________________ Check appropriate space: Single___ Married___ Divorced___ Separated___

### 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________________________

## 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:

| PORTION | OUR FEE | YOUR EST. |
|---|---|---|
| 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**_______________