Date ____________

Patient Name ____________ Date of Birth ____________

Street ____________ City ____________ Zip ____________

Home Phone ( ) ____________ Employer ____________

Work Phone ( ) ____________ Occupation ____________

Marital Status S M D W Soc. Sec. # ____________

Spouse's Name ____________ Employer ____________

INSURANCE INFORMATION

Dental Insurance ____________ Subscriber ____________ DOB ____________

Subscriber's I.D.# ____________ Employer ____________

Group # ____________ * If college student; name and address of college: ____________

____

A TEMPORARY FILLING WILL BE PLACED AFTER ROOT CANAL TREATMENT AND YOU MUST RETURN TO YOUR GENERAL DENTIST FOR PERMANENT RESTORATIONS.

I the undersigned, give permission for treatment and I understand I am personally responsible for any amount that insurance does not cover; quotes from my insurance company is not a guarantee of benefits and my estimated co-payment is due at the time treatment is completed. I understand if my insurance company does not pay the practice within a reasonable length of time (45 days) I will be billed for payment.

Signature ____________

Medical History

Heart Problems Yes No
(coronary, angina, murmur
heart or valve surgery) Yes No
Pacemaker Yes No
Rheumatic Fever Yes No
High Blood Pressure Yes No
Low Blood Pressure Yes No
Bleeding Tendencies Yes No
Anemia Yes No
Diabetes Yes No
Hepatitis Yes No
(if yes last date tested negative) ____________
Colitis Yes No
Asthma Yes No
Ulcers Yes No
Kidney Problems Yes No
Liver Problems Yes No
Thyroid Problems Yes No
Sinus Problems Yes No
Venereal Disease Yes No
HIV Yes No
AIDS Yes No
Glaucoma Yes No
Epilepsy or Seizures Yes No

Are you allergic to any of the following?
Penicillin Yes No
Aspirin Yes No
Codeine Yes No
Local Anesthesia Yes No
(novacaine)
Other Medications Yes No
Latex Yes No
Other Allergies Yes No

____

Do you have any medical problems
not listed above Yes No

____

____

Please list any medications you are taking.
(including birth control)

____

____

Your Physicians name and address:

____

____

Women: Are you pregnant? Yes No
Did you receive the patient information brochure?
Yes No

Who may we thank for referring you to us? ____________

Emergency Contact Name: ____________ Phone ( ) ____________

1. I hereby authorize Dr. ______________________________ and any other agents or employees of ______________________________ and such assistants as may be selected by any of them to treat the condition(s) described below:

____

____

2. The procedure(s) necessary to treat the condition(s) have been explained to me, and I understand the nature of the procedure(s) to be: ______________________________

____

3. The prognosis for this(these) procedure(s) was described as: ______________________________

____

4. I have been informed of possible alternative methods of treatment including no treatment at all.

5. The doctor has explained to me that there are certain inherent and potential risks in any treatment plan or procedure. I understand that the following may be inherent or potential risks for the treatment I will receive:
   swelling; sensitivity; bleeding; pain; infection; numbness and/or tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is transient but on infrequent occasions may be permanent; reactions to injections; changes in occlusion (biting); jaw muscle cramps and spasm; temporomandibular joint difficulty; loosening of teeth, crowns or bridges; referred pain to ear, neck and head; delayed healing; sinus perforations; treatment failure; complications resulting from the use of dental instruments (broken instruments—perforation of tooth, root, sinus), medications, anesthetics and injections; discoloration of the face; reactions to medications causing drowsiness and lack of coordination; and antibiotics may inhibit the effectiveness of birth control pills.

6. It has been explained to me and I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted.

7. I have been given the opportunity to question the doctor concerning the nature of treatment, the inherent risks of the treatment, and the alternatives to this treatment.

8. This consent form does not encompass the entire discussion I had with the doctor regarding the proposed treatment.

Patient's signature ______________________________ Date/time ____________

Doctor's signature ______________________________ Date/time ____________

Witness's signature ______________________________ Date/time ____________

Updated 9/97