PATIENT INFORMATION

Please fill out form completely and hit the 'print' button at the bottom of the page

Title		First Name		Last Name		Initial	
Home Address		City		State	CA	Zip	
Home Phone		Work Phone		Mobile Phone			
Fax Number		Home Email		Work Email			
Social Security		Date of Birth					
Occupation		Employer Name					
Employer Address							
Referred By		General Dentist					
Guarantor (if minor)		Guarantor Phone Number					
Dental Insurance Co		Address					
Subscriber Name		Subscriber Social Security Number					
Subscriber Birth Date		Group Number and Employer Name		Relationship			

CONSENT FOR ENDODONTIC THERAPY

I understand root canal therapy is a procedure that retains a tooth, which may otherwise require extraction. As a specialty practice, this office performs only endodontic therapy and associated surgery. Although root canal therapy has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth, which has had root canal therapy, may require retreatment, surgery, or even extraction. Following treatment, the tooth may be brittle and subject to fracture. A restoration (filling), crown and/or post and core will be necessary to restore the tooth, and your general dentist will perform these procedures. During endodontic treatment, there is the possibility of instrument separation within the root canals, perforations (extra openings), damage to bridges, existing fillings, crowns or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals, and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when a tooth may not be amenable to endodontic treatment at all. Other treatment choices include no treatment, a waiting period for more definitive symptoms to develop, or tooth extraction. Risks involved in those choices might include, but are not limited to, pain, infection, swelling, loss of teeth, and infection in other areas.

Occasionally, medication will be prescribed. Medications prescribed for discomfort and/or sedation may cause drowsiness, which will be increased by the use of alcohol or other drugs. We advise that you do not operate a motor vehicle or any hazardous device while taking such medications. In addition, certain medications may cause allergic reactions, such as hives or intestinal discomfort. If any of these problems occur, call the office immediately. It is the patient's responsibility to report any changes in his/her medical history to the Dr.

Furthermore, I give **West View Endodontics** my permission to take digital photos of my procedure for purposes of completing my medical record and/or for patient education.

All accounts must be paid in full at the time treatment is rendered unless special arrangements are made prior to any treatment. Accounts 90 days past due are subjected to a 17% interest charge, and/or, transition to a collection recovery agency.

Signature:_____ Date:_____

Must be signed by a legal guardian if this is a minor

Medical History

1. Do you have any unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? ◯ Yes ◯ No ◯ Don't Know

2. Has there been any change in your general health within the past year. ◯ Yes ◯ No ◯ Don't Know

If yes, explain

3. Are you under the care of a physician for a current problem? ◯ Yes ◯ No ◯ Don't Know

If yes, explain

4. Have you been hospitalized within the past 5 years? ◯ Yes ◯ No ◯ Don't Know

please specify

5. Have you received therapy for alcoholism or drug addiction during the past 5 years? ◯ Yes ◯ No

6. Have you ever had any **ALLERGIC** or **ADVERSE REACTIONS** to anesthetics/antibiotics/medications ◯ Yes ◯ No

If yes, explain

7. Is there any condition concerning your health that the doctor should be told? ◯ Yes ◯ No

If yes, explain

8. Do you wish to speak to the doctor privately about anything? ◯ Yes ◯ No

9. Have you had abnormal bleeding with previous extraction's, surgery, or trauma? ◯ Yes ◯ No

10. Have you ever required a blood transfusion? ◯ Yes ◯ No

11. Have you ever had radiation for any condition? ◯ Yes ◯ No

12. Have you ever tested positively for HIV infection or AIDS? ◯ Yes ◯ No

13. Are you **required to take antibiotics prior to all dental treatment per your physician?** This is often recommended due to a medical history of joint replacement or MVP, RH Fever or other heart conditions. **This does not include patients who are on a normal prescription of antibiotics for tooth infection.** ◯ Yes ◯ No

14. Are you taking any herbal medicine (i.e. St. Johns Wort)? ◯ Yes ◯ No

15. Have you taken the "fen-phen" diet? ◯ Yes ◯ No

16. Are you taking or have you ever taken any bisphosphonates in the past? ◯ Yes ◯ No
(Fosamax or drug class related to bone fragility)

17.Are taking any medication or drugs. ◯ Yes ◯ No

If yes please list them below, with dosage, frequency, and reason needed

Drug		Dose		Reason	
Drug		Dose		Reason	
Drug		Dose		Reason	
Drug		Dose		Reason	
Drug		Dose		Reason	
Drug		Dose		Reason	
Drug		Dose		Reason	

18. ***Do you have or have you had any of the following? Please check only those that apply.***

☐ High Blood Pressure	☐ Diabetes	☐ Cancer
☐ Heart Murmur or prolapsed valve	☐ Stomach ulcers, colitis	☐ Tempromandibular joint problems (TMJ)
☐ Joint prosthesis	☐ Hepatitis, jaundice, liver disease	☐ Low blood sugar
☐ Rheumatic Fever or rheumatic heart disease	☐ Kidney problems	☐ Dialysis
☐ Congenital heart disease	☐ Swollen Ankles, arthritis or joint disease	☐ Irregular heart beat
☐ Prosthetic heart valve	☐ Allergy to latex	☐ X-ray treatment or chemotherapy
☐ Blood disorder (e.g. anemia)	☐ Low Blood Pressure	☐ Contagious diseases
☐ Venereal disease	☐ Chest pain, angina	☐ Hay fever or sinus problems
☐ Asthma	☐ Heart Surgery	☐ Problems with the immune system
☐ Cardiovascular disease, heart attack, stroke, or bypass	☐ Delay in healing	☐ Difficult breathing or other lung trouble
☐ Bronchitis, chronic cough	☐ Tuberculosis	☐ Chronic fatigue or night sweats
☐ History of alcohol abuse	☐ Emphysema	☐ History of drug abuse
☐ Eye disease or glaucoma	☐ On a diet	☐ Wears contact lenses
☐ Infectious Mononucleosis	☐ Psychiatric treatment	☐ Bruise easily
☐ Sinus trouble	☐ Fainting spells	☐ Gallbladder trouble
☐ Thyroid problems	☐ Epilepsy	☐ Cardiac pacemaker

Women Only:

Possibility of pregnancy? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Estimated delivery date: _____ Taking birth control pills? ◯ Yes ◯ No

Note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist regarding additional methods of control.

Injury Only:

This visit is related to an accident ◯ Yes ◯ No Work related ◯ Yes ◯ No

Insurance company _____ Claim Number: _____ Date of Injury _____

PHYSICIAN NAME: _____ SPECIALIST NAME: _____

PHYSICIAN PHONE: _____ SPECIALIST PHONE: _____

Emergency Contact Name: _____

Emergency Contact Number: _____

Both Doctor and Patient are encouraged to discuss any and all patient health issues prior to treatment. I certify that I have read and understood the above. I will not hold my dentist or any member of his staff, responsible for actions they take or do not take because of errors or omissions that I may have made in completing and updating this form.

Patient Signature _____ Date _____

Must be signed by a legal guardian if this is a minor

The following HIPPA page is for you to read or keep.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Patient Signature _____ Date _____

PATIENTS WITH DENTAL INSURANCE REVIEW & SIGN

Dear Patient,

The major objective of our office is to provide you with the best quality dental care available anywhere. This service is based on a friendly, mutual, but business-like understanding between Doctor and patient. In order to prevent misunderstandings we would like you to read the following and sign the acknowledgement at the bottom. We would like to explain our policy regarding your dental insurance.

As a courtesy we will file your claim for you. We can only file claims on your behalf. The benefits belong to you, and it is up to you to ensure that you are receiving appropriate reimbursement under the terms of your specific plan. We encourage you to verify your benefits with your carrier if you have any concerns as to the coverage they offer you in our office.

Your estimated co-payment will be due at the time service is rendered. In certain instances we can make payment arrangements if necessary. If this is necessary please talk this over with the office manager prior to your treatment.

Your insurance company is only giving us an estimate based on their benefit structure and they also will not guarantee payment in advance. Therefore we can only give you an estimate of payment and your co-payment amount. Once again, it is not a guarantee of payment, as your insurance will not give any provider a guarantee of payment.

Your policy is a contract between you and your carrier. Professional services are rendered to a person, not an insurance company. Therefore, the patient is responsible to us for payment. The insurance company is responsible to you for their contract benefits.

Your insurance will be billed immediately upon completion of your treatment. **If your insurance does not pay us within 90 days of the date of service, you are responsible for the balance at that time .**We will instruct your carrier to remit their portion directly to you in this case. Most all carriers remit their payment within 40/60 days.

We do not carry balances over 90 days from the date service is provided. We can only estimate your co-payment not guarantee it. If our estimate differs from the insurance company's actual payment you are still responsible for that difference.

I have read and understood the above policy.
(If you have any questions please ask the office manager prior to signing)

Patient Signature _____ Date _____

Print this form and bring with you to our office

Click to Print Form