ABQ ENDODONTICS

ABOUT YOU

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. ☐ Minor

Patient Name____________________

Name you like to be called____________________

Street Address____________________

City__________ State__________ Zip__________

Home Phone____________________

Work Phone____________________

Cell Phone____________________

Best number to reach you?____________________

Employer____________________

Occupation____________________

Birthdate____________________ ☐ Male ☐ Female

Social Security Number____________________

Email Address____________________

Today's date____________________

Referred by____________________

Name of general dentist____________________

In case of emergency, please contact:

Name____________________

Relationship____________________

Work phone__________Home phone __________

Person responsible for your bill____________________

Relationship to patient____________________

Billing address, if different from home address:

Address____________________

City, State, Zip____________________

How did you find our office?

___General Dentist ___Friend ___Internet ___Phone book

DENTAL INSURANCE

Do you have dental insurance? ☐Yes ☐ No

Dental Insurance company____________________

Group number ____________________

Insurance company phone # ____________________

Person with primary coverage ____________________

Their birthdate ____________________

Their employer____________________

Their Social Security or ID#____________________

MEDICAL HISTORY

Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain____________________

____

Physician's name and phone number____________________

Are you currently taking any medications or herbal supplements? ☐ Yes ☐ No

If yes, please list medications and/or supplements and doses per day____________________

____

____

Are you pregnant or breast feeding? ☐ Yes ☐ No Due date____________________

If applicable, are you taking birth control? ☐ Yes ☐ No

Do you require antibiotics for joint replacements or heart conditions prior to dental treatment? ☐ Yes ☐ No

Have you ever taken any bone density related treatment medications? (ie. bisphosphonates) ☐Yes ☐ No

Have you ever had an abnormal response to dental treatment or dental anesthetic? ☐ Yes ☐ No

Are you allergic to any of the following?

Penicillin/ Amoxicillin	☐ Yes ☐ No	Doxycycline/ Tetracycline	☐ Yes ☐ No
Sulfa drugs	☐ Yes ☐ No	Erythromycin	☐ Yes ☐ No
Latex	☐ Yes ☐ No	Codeine	☐ Yes ☐ No
Aspirin	☐ Yes ☐ No		

Are you allergic to any other drugs or substances? ☐ Yes ☐ No

If yes, please list____________________

Do you have or have you ever had any of the following diseases or medical conditions? (If yes, please describe details)

Heart disease	☐ Yes ☐ No	Pacemaker/Defibrillator	☐ Yes ☐ No
Heart surgery	☐ Yes ☐ No	Low blood pressure	☐ Yes ☐ No
Heart defect	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No
Rheumatic fever	☐ Yes ☐ No	Arrhythmia	☐ Yes ☐ No
Heart murmur	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No
Artificial heart valve	☐ Yes ☐ No	Drug dependency	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Alcohol dependency	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Emphysema/ COPD	☐ Yes ☐ No

Sinus/ Ear problems ☐ Yes ☐ No Seizures ☐ Yes ☐ No

Do you have or have you ever had any of the following diseases or medical conditions? (If yes, please describe details)

Liver disease ☐ Yes ☐ No Kidney disease ☐ Yes ☐ No

Osteoporosis ☐ Yes ☐ No Cancer/ Leukemia ☐ Yes ☐ No If yes, when? _______________

Lupus ☐ Yes ☐ No Bleeding disorder ☐ Yes ☐ No

Asthma ☐ Yes ☐ No HIV/AIDS ☐ Yes ☐ No

Tuberculosis ☐ Yes ☐ No Bronchitis ☐ Yes ☐ No

Depression/ Anxiety ☐ Yes ☐ No Headaches/ Migraines ☐ Yes ☐ No

Hypo/Hyperthyroidism ☐ Yes ☐ No Diabetes ☐ Yes ☐ No Type_____________________

Ulcers/ colitis ☐ Yes ☐ No Jaw pain or disorder ☐ Yes ☐ No

Heart attack ☐ Yes ☐ No If yes, when?____

Stroke ☐ Yes ☐ No If yes, when?____

Hepatitis ☐ Yes ☐ No If yes, what type?_____ and what year was it diagnosed?__________________________

Any other medical condition not listed? ☐ Yes ☐ No If yes, please list. (space provided also to describe conditions from list above) ____

____

____

INFORMED CONSENT

I Authorize an exam, and/or, treatment if necessary on ____

Name of Patient

I understand that root canal treatment is an attempt to save a tooth which otherwise would be lost.

Although root canal treatment has a very high degree of success, it cannot be guaranteed. Reputable practitioners cannot guarantee results. A tooth which has had root canal treatment may require re-treatment, surgical intervention, or even extraction.

I also understand that I will need to return to my general dentist for the placement of a permanent filling and/or crown after completion of root canal treatment.

Although unlikely, there are certain inherent and potential outcomes in any treatment plan or procedure. I understand the following potential outcomes of treatment: pain; swelling; infection; numbness; bleeding; bruising; damage to teeth and/or adjacent tissues; damage to crowns and/or bridges; sinus communication; and instrument separation.

I understand that I am financially responsible for all fees including any collection costs, attorney costs, and any court costs associated with the payment of fee for service.

The fee that is quoted is for the doctor's time and service, apart from the outcome

I have read and agree to the above consent.

_____________________________________ _____________________________________

Signature of Patient or Responsible Party Date

AKNOWLEDGEMENT OF PRIVACY RIGHTS

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

1. Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly or indirectly.
2. Obtain payment from third-party payers for my health care services
3. Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices,* and that I may contact this office to obtain a current copy of the practices.

I understand that I may request in writing that this office restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I understand that the office is not required to agree to my requested restrictions, but if the office does agree then it is bound to abide by such restrictions.

Patient Name_____________________________________ Date_____________________________________

Signature_____________________________________

Relationship to Patient_____________________________