ABQ ENDODONTICS

ABOUT YOU

□ Mr. □ Mrs. □ Miss □ Ms. □ Dr. □ Minor

Patient Name_____

Name you like to be called_____

Billing 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_____

Address_____

City, State, Zip_____

How did you find our office?

___General Dentist ___Friend ___Internet ___Phone book

DENTAL INSURANCE

Primary **Dental** Insurance Company_____

Person with Primary Coverage_____

Member ID or SS#_____

Birthdate of person with primary coverage _____

Employer of person with primary coverage_____

Secondary **Dental** Insurance Company_____

Person with Secondary Coverage_____

Member ID or SS#_____

Birthdate of person with secondary coverage_____

Employer of person with secondary coverage_____

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 have any heart conditions or joint replacements that require premedication 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	Clindamycin	□ Yes □ No
Aspirin/Ibuprofen	□ Yes □ No	Codeine	□ 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 When _____	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 When _____	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 Type_____	Kidney disease	□ Yes □ No		
Osteoporosis/penia	□ Yes □ No	Cancer/ Leukemia	□ Yes □ No	Type_____	when_____
Lupus	□ Yes □ No	Bleeding disorder	□ Yes □ No		
Asthma	□ Yes □ No	HIV/AIDS	□ Yes □ No		
Tuberculosis	□ Yes □ No When_____	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	Type_____	

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 understand that I will need to return to my general dentist within 1 month of treatment for the placement of a permanent filling and/or crown as failure to do so may cause contamination or fracture and possible failure of the root canal.

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; TMJ pain; sinus communication; and instrument separation.

Tenderness from the root canal is expected for 2-3 days; however, sensitivity may last longer. I also understand there is a possibility of a flareup (swelling and/or intense pain) following root canal treatment.

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 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_____