PATIENT REGISTRATION AND MEDICAL HISTORY FORM

Patient's Full Name: _____ circle⇨ Male Female

Mailing Address: _____ City: _____ State: _____ Zip: _____

Marital Status: circle⇨ M S W D Birth Date: _____ SSN _____

Home Phone #: _____Spouse's Name: _____ SSN _____

Spouse's Birth Date: _____

Person responsible of account: circle⇨ Self Spouse Parent* Other*

*If parent or Other, please list name, address, employer, phone #, S.S.#, birth date and insurance on the back of this sheet.

Your Employer: Name: _____ Address: _____

Phone: _____ Position: _____

Spouse's Employer: Name: _____ Address: _____

Phone: _____ Position: _____

Where may we leave a message: circle⇨ Home Work Other_____

Primary Dental Insurance Company:_____

Carrier (Family Member) _____ Group # _____Agreement # _____

Referring Dentist: _____How long have you been his/her patient?___

Is this Appointment for: circle⇨ Consultation Treatment Both

Have you or any family member been a patient here? circle⇨ No Yes When Who_____

Are you in pain? circle⇨ No Yes

Has your dentist prescribed any medication? circle⇨ No Yes List

Have you previously had a root canal? circle⇨ No Yes When_____

In case of emergency contact _____ *Phone* _____

PERMISSION FOR X-RAYS, CONSULTATION AND/OR ROOT CANAL PROCEDURES

To the best of my knowledge, all answers on this form are correct. I will notify the doctor of any changes in my health or medications.

I, the undersigned, consent to the dental procedures decided upon to be necessary or advisable in the opinion of the doctor, of which I am informed and to which I agree.

I also understand that only the root canal treatment is to be completed at this office. The permanent (outside) restoration (filling, inlay, crown, etc.) will be performed by my general dentist.

How will you be paying for your treatment today?

circle⇨ Visa Mastercard Am. Exp. Discover Check # _____ Cash

SIGNATURE:_____ Date: _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician _____

Date of last physician examination _____ Purpose _____

What is your estimate of your general health? Poor _____ Fair _____ Good _____

HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
1. hospitalization for illness or injury	❑	❑
2. allergic reaction to	❑	❑
❑ aspirin ❑ penicillin ❑ erythromycin ❑ codeine ❑ local anesthetic ❑ fluoride ❑ metals (gold, stainless steel) ❑ any other medications_____		
❑ latex ❑ nitrous oxide ❑ sulfa drugs ❑ benzodiazepines (valium, Ativan, etc.)		
3. heart problems	❑	❑
please list _____		
4. heart murmur	❑	❑
5. rheumatic fever	❑	❑
6. scarlet fever	❑	❑
7. high blood pressure	❑	❑
8. low blood pressure	❑	❑
9. pacemaker	❑	❑
10. a stroke	❑	❑
11. artificial prosthesis	❑	❑
please list (i.e. heart valve or joints)_____		
12. anemia or other blood disorder	❑	❑
13. prolonged bleeding	❑	❑
14. emphysema	❑	❑
15. tuberculosis	❑	❑
16. asthma	❑	❑
17. bronchitis	❑	❑
18. sinus problems	❑	❑
19. kidney disease	❑	❑
20. liver disease	❑	❑
21. jaundice	❑	❑
22. thyroid or parathyroid disease	❑	❑
23. hormone deficiency	❑	❑
24. high cholesterol	❑	❑
25. diabetes	❑	❑
26. bruise easily	❑	❑
27. G.E. reflux	❑	❑
28. stomach or duodental ulcer	❑	❑
29. digestive disorders	❑	❑
30. arthritis	❑	❑
31. glaucoma	❑	❑
32. contact lenses	❑	❑
33. head or neck injuries	❑	❑
34. epilepsy, convulsions (seizures)	❑	❑
35. viral infections and cold sores	❑	❑
36. any lumps or swelling in the mouth	❑	❑
37. hives, skin rash, hay fever	❑	❑
38. sexually transmitted disease	❑	❑
39. hepatitis (type _____)	❑	❑
40. HIV / AIDS	❑	❑
41. cancer, type _____	❑	❑
42. radiation therapy	❑	❑
43. chemotherapy	❑	❑
44. emotional problems	❑	❑
45. psychiatric treatment	❑	❑
46. antidepressant medication	❑	❑
47. alcohol / drug dependency	❑	❑
48. dry mouth	❑	❑
ARE YOU:		
45. aware of a change in your general health	❑	❑
46. often exhausted or fatigued	❑	❑
47. subject to frequent headaches	❑	❑
48. a heavy smoker (1 pack or more a day)	❑	❑
49. often unhappy or depressed	❑	❑
50. easily upset or irritated	❑	❑
51. FEMALE - taking birth control pills	❑	❑
52. FEMALE - pregnant	❑	❑
44. FEMALE - breast feeding	❑	❑
53. MALE - Prostate disorders	❑	❑

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment, (include current illnesses, previous surgeries and hospitalizations) _____

_____

List any medications taken within the last two years _____

_____

List any other drugs taken in the past 2 years (steroids, cocaine, recreational drugs, herbal remedies and vitamins...)

_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

I certify that I have read & understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient's Signature: _____ Date: _____

Doctor's Remarks: _____

_____ Doctor's Signature _____

GLACIER VALLEY
ENDODONTICS

Endodontic Consent and Information

Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to removed. This is accomplished by the conventional root canal therapy (through the top of the tooth) or when needed, endodontic surgery (performed through the gum). The following discusses possible risks and alternative treatment choices.

General Risks

Included, but not limited to, are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain medication), anesthetics, canal disinfectant materials (including sodium hypochlorite, chlorhexidine) and injections. These complications may include: swelling, bruising, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, face and teeth (which is usually transient, but on infrequent occasions may be permanent), reactions to injections, nausea, vomiting, allergic reactions, delayed healing, sinus perforations, and treatment failure.

Other risks include the possibility of instruments broken within the root canals; overextension of the filling material beyond the end of the root; perforations (extra opening) of the crown or root of the tooth; damage to bridges, existing fillings, crowns, or porcelain veneers; loss of tooth structure in gaining access to canals; and cracked teeth. During treatment, complications may be discovered which make treatment impossible or which may require dental surgery. These complications may include blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), and splits or fractures of the teeth.

If the tooth is covered by a crown, I understand that a hole must be drilled through the crown to access the root canal system. I understand that the crown or adjacent teeth/crowns may be damaged in the process, requiring a new crown or repair.

Medications & Other Treatment Choices

Some prescribed medications and drugs may cause drowsiness and lack of awareness and co-ordination (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effects.

Other treatment choices include no treatment, waiting for more definitive development of symptoms, and tooth extraction. Risks involved in these choices might include pain, infection, swelling, tooth loss, and spread of infection to other areas of the body.

Signature_____

Consent

I, the undersigned, being the patient (parent or guardian of minor patient) consent to performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. I also understand that upon completion of root canal therapy in this office, I shall return to my general dentist for a permanent restoration of the tooth involved, such as a crown or filling.

I understand that root canal treatment is an attempt to save a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed.

Occasionally, a tooth which has had root canal therapy may require retreatment, surgery, or even extraction.

In some instances the doctor may determine and recommend a permanent restoration be placed after root canal treatment has been completed. I understand that there is a separate fee for this procedure in addition to the fee for root canal treatment. I have also been given the opportunity to discuss the different restoration materials advantages and disadvantages with the doctor and have been given a choice between the different materials to be placed. Fee for Treatment_____
Initials_____

I hereby state that I have read and understand this consent. I have been given the opportunity to ask questions and they have been answered for me. This consent form does not encompass the entire discussion I had with the doctor regarding the proposed treatment. I am medically and physically competent to understand this form and have not taken any mood or mind-altering drugs during the twelve hours prior to signing this document.

$_____. Corrections:_____.
Fee for Treatment

_____.
Tooth/Teeth

Patient Signature:_____ Date:_____.

Witness Signature:_____ Date:_____.

GLACIER VALLEY
ENDODONTICS

Financial Policy

Payment is due in full at time of service for all procedures. We gladly accept Visa, Mastercard, American Express, Discover, debit cards, checks and cash. For patients without dental insurance a 5% discount is given for cash. Six month, no interest payment plans are available through Care Credit, and Chase Healthcare Financial and are subject to approval from these companies. Applications for these plans can be accessed through our website or by phone: Care Credit - 1 (800) 365-8295 and Chase financial - 1 (800) 510-5638.

If you have dental insurance, 50% of the total is due at the time treatment is rendered, with the exception of Blue Cross/Blue Shield. Payment is due in full at the time of service for patients with Blue Cross/Blue Shield, as they pay the patient back directly. As a courtesy to you, we will gladly process and submit your insurance claim. ***However, if this claim is not paid by your insurance company within 30 days, the balance is your responsibility and due immediately.*** If your account has not been paid in full within 45 days after the date of service, a late charge will be assessed. If there is a balance to you on your account after insurance has paid your claim, a check for the difference will be sent to you. Claims are filed on behalf of our patients for dental services performed in the office to the primary insurance company. Secondary insurance is the patient's responsibility. To assist in filing your secondary claim, we will give you a complete statement of services from our office. Dental insurance benefits belong to you, and it is up to you to ensure that you are receiving appropriate reimbursement under the terms of your plan. There is no guarantee of benefits from the insurance company until a claim is received and processed by the insurance company. Therefore, benefits quoted to you are only an estimate provided by the insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY ME DENTAL BENEFITS DIRECTLY TO THE DOCTOR.

Patient's Name (Printed) _____

Signature of Patient / Guardian _____

Date _____

GLACIER VALLEY
ENDODONTICS

Appointment Policy

From the very first appointment, we try to establish open lines of communication with our patients, with mutual understanding in place; we can work cooperatively toward the same goal: sustained dental health.

Due to the nature of our specialty most often we see patients who are in pain and in need of immediate care, therefore our appointment times are very valuable to our patients.

When we schedule a dental visit for you, that time is yours. It belongs to you. You deserve our undivided attention. **So when a cancellation happens without proper notice someone else that is in pain has lost the opportunity to get the care they need.**

Due to the importance of our appointments we require a 24-hour cancellation notice. There will be a cancellation fee of $75.00 if we do not receive a minimum of 24 hours notice

We are dedicated to providing state-of-the-art endodontic services to all our patients, and our staff has made a promise, professionally and personally, to give you the concern, respect and care that make our office a comfortable and pleasant place to visit. We thank you in advance for your cooperation in keeping your scheduled appointments.