ASSOCIATED ENDODONTISTS OF MELBOURNE

AEM

# WELCOME TO OUR OFFICE...

| PATIENT INFORMATION | | | REFERRING DENTIST: | |
|---|---|---|---|---|
| NAME | | | EMERGENCY CONTACT | |
| BIRTHDAY | | | PHONE NUMBER | |
| SOCIAL SECURITY NO. | | | RELATION | |
| EMPLOYER | | | All fees are payable when service is rendered. Payment delayed beyond 30 days may incur additional charges. Delinquent accounts are subject to finance charges and collection fees. There is a fee for returned checks. | |
| HOME ADDRESS | | | | |
| CITY | STATE | ZIP | DENTAL INSURANCE INFORMATION | |
| CELL PHONE | WORK PHONE | | INSURANCE COMPANY | |
| HOME PHONE | | | EMPLOYEE NAME | DOB |
| EMAIL | | | MEMBER # | GROUP NO. |
| RESPONSIBLE PARTY - MINOR PATIENT | | | RELATION TO EMPLOYEE SELF ( ) SPOUSE ( ) CHILD ( ) | |
| NAME | | | SECONDARY INSURANCE CO. | GROUP NO. |
| BIRTHDAY | PHONE NUMBER | | EMPLOYEE NAME | |
| SOCIAL SECURITY NO. | | | RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS | |
| EMPLOYER | | | I authorize the release of any dental information necessary in order to process insurance claims, and I authorize payment of dental benefits to Associated Endodontists of Melbourne, P.A. for professional services rendered. I agree that I am responsible for all dental fees and that my insurance is filed as a courtesy to me. I am responsible for any outstanding insurance balance of over 60 days of date of service. INITIAL _____ | |
| HOME ADDRESS | | | | |
| CITY | STATE | ZIP | | |

## HEALTH HISTORY

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| AIDS or ARC | ❑ | ❑ | Drug/Alcohol Addiction | ❑ | ❑ | Liver Disease | ❑ | ❑ |
| Artificial Joint / Valve | ❑ | ❑ | Frequent Swollen Ankles | ❑ | ❑ | Low Blood Pressure | ❑ | ❑ |
| Asthma | ❑ | ❑ | Gastrointestinal | ❑ | ❑ | Lung Disease | ❑ | ❑ |
| Bleeding Tendency | ❑ | ❑ | HIV Positive | ❑ | ❑ | Nervous Problems | ❑ | ❑ |
| Bronchitis | ❑ | ❑ | Heart or Chest Pain | ❑ | ❑ | Pregnant | ❑ | ❑ |
| Cancer | ❑ | ❑ | Heart Murmur | ❑ | ❑ | Radiation Therapy | ❑ | ❑ |
| Chemotherapy | ❑ | ❑ | Heart Trouble/Pacemaker | ❑ | ❑ | Recent Illness | ❑ | ❑ |
| Convulsions/Seizures | ❑ | ❑ | Hepatitis (A or B or C) | ❑ | ❑ | Rheumatic Fever | ❑ | ❑ |
| Cortisone or Steriods | ❑ | ❑ | Herpes | ❑ | ❑ | Tuberculosis | ❑ | ❑ |
| Diabetes/Hypoglycemia | ❑ | ❑ | High Blood Pressure | ❑ | ❑ | Ulcerative Colitis | ❑ | ❑ |
| Dizziness/Faintness | ❑ | ❑ | Kidney Disease | ❑ | ❑ | Phen-fen/Redox | ❑ | ❑ |

| | YES | NO |
|---|---|---|
| Are you under the care of a physician? | ❑ | ❑ |
| Have you ever been hospitalized or had a serious illness? | ❑ | ❑ |
| Have you ever responded unfavorably to medical or dental care? | ❑ | ❑ |
| Is there anything else you think we should know about? | ❑ | ❑ |
| Have you ever had a root canal before? | ❑ | ❑ |

Dr.: _____

_____

_____

_____

_____

HAVE YOU HAD AN UNFAVORABLE ALLERGIC REACTION TO:

❑ None ❑ Codeine ❑ Erythromycin ❑ Latex
❑ Penicillin ❑ Keflex ❑ Anesthetics ❑ Cleocin
❑ Other (List)_____

I AM PRESENTLY TAKING:

❑ No Drugs ❑ Pain Medicine ❑ Aspirin ❑ Blood Thinner
❑ Antibiotic ❑ Heart Medicine ❑ Cortisone/Steroids ❑ Blood Pressure Medicine
❑ Other (List) _____

**PATIENT SIGNATURE**_____ **Reviewed by:** **Date:**

Update: _____ Update: _____ Update: _____ Update: _____

ASSOCIATED ENDODONTISTS OF MELBOURNE

**Paul A. Scott, D.D.S., M.S.**
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# ENDODONTIC CONSENT and FINANCIAL AGREEMENT

We want to inform our patients about the various procedures involved in endodontic therapy and have their consent before starting treatment. Endodontic (root canal) therapy is performed to save a tooth which might otherwise need to be removed. The alternatives to endodontic therapy include no treatment, waiting for more definite development of the symptoms, and tooth extraction. Risks involved in these choices might include pain, infection, swelling, and tooth loss.

Endodontics or root canal therapy is the cleaning, shaping, disinfecting, and filling of the root canal(s) of the diseased tooth. The root canal is the space inside the root of the tooth. A treated tooth usually functions normally and is a pulpless tooth, not a dead tooth. Treatment will require one or more visits depending upon the condition of the tooth. Please be advised of the following:

1. As a rule, 90-95% of routine cases are successful. Endodontics, as with any branch of medicine or dentistry, is not an exact science. Thus no guarantee of treatment success can be given or implied. If the original treatment is not successful, it may have to be redone, a surgical procedure may be required, or the tooth may need to be removed.

2. Endodontic treatment started in other offices or retreatment cases may have a different outcome than expected under optimal conditions.

3. Proper post-treatment restoration of the treated tooth is a necessity. Please contact your dentist soon after the completion of treatment here so that he/she may restore of the crown portion of your tooth.

4. Possible unavoidable complications of endodontic therapy include:
   a. procedural difficulties in the course of treatment.
   b. swelling, soreness, infection, muscle spasm, or discoloration of the soft or hard tissues.
   c. fracture of the crown or root of the tooth.
   d. separation of root canal instruments during treatment.
   e. perforation or stripping of the root with instruments.
   f. underfills and overfills of the root canal; sinus perforation.
   g. damage to bridges, existing fillings, crowns or veneers.
   h. blocked canals due to fillings or prior treatment, natural calcifications, severely curved roots, and root resorptions.

5. During treatment complications may be discovered which make completion impossible or which may require dental surgery.

Treatment will be performed in accordance with accepted methods of clinical practice. Included in treatment will be the taking of a minimal number of x-rays as indicated by the needs of treatment.

Almost always a local anesthetic will be needed to anesthetize (numb) your tooth. Although complications are rare, they can include the following: swelling; sensitivity; bleeding; pain; infection; numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth which is transient but on very infrequent occasions may be permanent; jaw muscle cramps and spasm; trismus; rapid heartbeat; and allergic reactions.

If surgery is indicated for the treatment of your tooth after it has had endodontic treatment here or elsewhere, there is a 75% chance that this will result in the retention of the tooth. As with any medical procedure there are complications associated with such surgery. These include treatment failure, delayed healing, sinus perforation, swelling, discoloration, sensitivity, postoperative infection, jaw muscle cramps and spasm, and numbness and tingling in the lip, tongue, chin, gums, cheeks or teeth which is usually transient but which on very infrequent occasions may be permanent.

Prescribed pain medications may cause drowsiness and lack of awareness and coordination (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.

## FINANCIAL AGREEMENT

The total fee amount is due at time of treatment unless you have dental insurance. Your **estimated** insurance co-payment is paid at the beginning of treatment, and assignment of the insurance benefits to us. If the insurance payment is received, and if there is an overpayment, a refund will be sent to you. If there is an additional amount due, we will send a statement for the balance which will then be **immediately** payable in full.

Any fees quoted for treatment are good for 90 days.

There will be a minimum $25 fee for returned checks.

**Any account with an outstanding balance after 30 days will be charged interest at 1.5% per month.**

I understand that if payment is not made when the account is due the account may be turned over for collection. I will be responsible for any and all costs associated with the collection procedure, including but not limited to billing costs, collection fees, lawyers fees, and court costs.

All of my questions have been answered by the doctor and I fully understand the above statements in the consent form. I hereby give my consent to the performance of endodontic therapy on the tooth or teeth listed above. I further give my consent for the administration of medications, anesthetics, drugs, and services deemed necessary to treat my endodontic problem, understanding that risks are involved.

I hereby authorize and request you to release to my dentist and/or to my insurance company the complete dental records in your possession concerning my treatment in this office.

_____ _____

(Patient Signature) (Staff Signature) (Date)