Brazos Valley Endodontic Associates

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Practice Limited to Endodontics

PATIENT REGISTRATION AND MEDICAL HISTORY

(PLEASE PRINT)

Patient: _____ Phone *(home):* _____ *(cell):* _____

Mailing Address:_____ City: _____ St: _____ Zip: _____

Email: _____ Social Security #: _____

Sex: M F Age: _____ Birth date:_____ ❒ Minor ❒ Single ❒ Married ❒ Widowed

If minor, parent or guardian's name: _____

Employed by: _____ Occupation: _____

Business Address: _____ Busines Phone:_____

Spouse Name: _____ Employer: _____ Occupation: _____ Birth date: _____

Who is responsible for this account?: _____

Whom may we thank for referring you? _____

Emergency Contact and Phone: _____

INFORMED CONSENT

I understand endodontic treatment is a procedure to retain a tooth which may otherwise require extraction. Although root canal therapies have a very high degree of success, a favorable outcome cannot be guaranteed. Occasionally, a tooth which has had a root canal may require retreatment, surgery, or even extraction. The alternatives to endodontic therapy include tooth extraction or no treatment.

Although rare, the following complications may occur associated with nonsurgical root canal treatment and nonsurgical root canal retreatment: pain, swelling, bruising, infection, limited jaw opening, damage to an existing crown or filling, fracture of a root, instrument separation in the root canal, overfill or overdrill, perforation of the tooth, altered sensations (paresthesia or anesthesia), adverse reactions to dental materials/anesthetics/medications administered, death, and/or failure of the procedure necessitating further treatment or extraction.

I understand that only the root canal treatment/retreatment is to be performed at this office. The permanent restoration (filling, crown, etc.) will be done by my general dentist at an additional expense. I understand that following completion of the endodontic treatment, a permanent restoration is required within 30 days to prevent reinfection of the tooth or tooth fracture.

I also accept full responsibility for the payment of services performed and agree to pay for them in full AT or BEFORE COMPLETION, unless other specific arrangements are made with the office. We reserve the right to charge for appointments cancelled or broken without 24-hour notice.

By providing my signature, I certify that I understand the treatment options, including risks and feasible alternatives to the proposed treatment. I have had a chance to have all my questions answered. By signing this form, I am freely giving my consent to allow and authorize Dr. Hays or Dr. Calkins to render any treatment necessary or advisable to my dental condition, including anesthetics and medications.

SIGNED _____ DATE_____

We will make every effort to see each regularly scheduled patient at his/her appointed time. However, this is not always possible due to the EMERGENCY NATURE of an endodontic practice. Accident cases, debilitating swelling, incapacitating pain and other emergency situations have to be given special consideration from a biological and humanitarian standpoint.

If you have not been seen at your appointment time, be assured that we are concerned and will see you as soon as possible. We sincerely apologize and appreciate your understanding.

(continued on back)

In the following questions, circle Yes or No, whichever applies, Your answers are for our records only and will be considered confidential.

1. Are you in good health? Y N

2. Do you have or ever had:

Asthma Y N
Anemia Y N
Thyroid trouble Y N
Glaucoma Y N
Kidney disease Y N
Ulcers (stomach or duodenal) Y N
Bleeding problems Y N
Growth or sores in mouth Y N
Pain in or near your ears Y N

3. Do you have a cardiac pacemaker? Y N
Mitral valve prolapse Y N
Rheumatic Fever Y N
Heart murmur Y N
Cardiovascular disease Y N
Heart attack Y N
High blood pressure Y N
Stroke Y N

4. Do you have pain in chest upon exertion? Y N

5. Are you ever short of breath? Y N

6. Do your ankles swell? Y N

Are you under the care of a physician? Y N
If so, what is the condition being treated?

_____

_____

Name of physicians:

_____

Phone #

_____

Name of family physician:

_____

Phone #

_____

8. Have you had any serious illness or operation in the last 5 years? Y N
If yes, what was the illness or operation?

_____

_____

Allergy Y N
Sinus trouble Y N
Hay fever Y N
Fainting spells Y N
Seizures Y N
Diabetes Y N
Hepatitis Y N
Jaundice Y N
Liver disease Y N
Arthritis Y N
Colitis Y N
Kidney trouble Y N
Tuberculosis Y N
Persistent cough Y N
Low blood pressure Y N
Sexually Transmissible disease Y N
Epilepsy Y N
Cancer Y N
Psychiatric problems Y N
Blood transfusion Y N
Artificial joint Y N
Other

_____

_____

9. Have you ever been tested for acquired immune deficiency syndrome (AIDS)? Y N
If so, negative/positive

10. Do you have any blood disorders? Y N

Have you ever taken drugs for epilepsy, psychiatric therapy, or blood clots? Y N

11. Have you ever taken steroids (cortisone prednisone, etc.) in the last two years? Y N

12. Are you currently taking any medications? Y N
If so, what?

_____

_____

13. Are you allergic to or have you reacted adversely to:

Latex Y N
Penicillin Y N
Other antibiotics Y N
Sulfa drugs Y N
Barbiturates Y N
Sedatives Y N
Sleeping pills Y N
Aspirin Y N
Iodine Y N
Codeine Y N
Other narcotics Y N
If so, what?

_____

14. Have you had any serious trouble associated with any previous dental treatment Y N
If so, explain

_____

_____

_____

15. Do you have any disease, condition, or problem not listed above that you think I should know about? Y N
If so, explain

_____

_____

_____

16. Are you hearing impaired? Y N

17. Is an interpreter needed? Y N

Women:

18. Are you pregnant? Y N

19. Are you nursing? Y N

20. Are you taking birth control pills? Y N