PATIENT REGISTRATION AND MEDICAL HISTORY

Welcome. Please take a few minutes to fill out this form as completely as you can.
If you have questions we'll be glad to help you. The information is confidential.

Patient Information Date_____

Patient _____

Address_____ City_____ State_____ Zip_____

ID/SS#_____ Sex ☐M ☐F Age_____ Birthdate_____ Status ☐S ☐M ☐W ☐D

Occupation_____ Employer_____

Employer Address_____ Employer Phone (_____)_____Ext____

Spouse's Name_____ Birthdate_____ SS#_____

Occupation_____ Employer_____

Whom may we thank for referring you?_____

Phone Numbers Do we have your permission to call to confirm appointments? Yes No

Home (_____)_____ Work (_____)_____Ext_____ Cell (____)_____

Spouse's Work (_____)_____ Best time and place to reach you_____

In case of emergency, contact _____ Relationship_____Phone (____)_____

Dental Insurance

Who is responsible for this account?_____Relationship to patient_____

Dental Insurance Co._____Group #_____

Is patient covered by additional (dental) insurance? ☐ Yes ☐ No If yes, please complete:

Subscriber Name_____Birthdate_____SS#_____

Relationship to Patient_____Insurance Co._____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr. Margaret Young, Professional Endodontics all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X_____ _____ _____

Responsible Party Signature **Relationship** **Date**

***** OVER PLEASE *****

Medical History

Personal Dentist_____ Phone (___)_____

Primary Physician_____ Phone (___)_____

Please circle "yes" or "no" to indicate if you have/have had any of the following:

AIDS/HIV	Yes	No
Anemia	Yes	No
Angina or Chest Pain	Yes	No
Artificial Heart Valves	Yes	No
Artificial Joints	Yes	No
Asthma	Yes	No
Bleeding abnormally,	Yes	No
with extractions or surgery	Yes	No
Blood Disease	Yes	No
Cancer	Yes	No
Chemical Dependency	Yes	No
Chemotherapy/Radiation	Yes	No
Cough, persistent	Yes	No
Diabetes	Yes	No
Epilepsy	Yes	No
Fainting or dizziness	Yes	No
Glaucoma	Yes	No
Headaches	Yes	No
Heart Murmur	Yes	No
Heart Problems	Yes	No
Hepatitis Type_____	Yes	No
Herpes	Yes	No
High Blood Pressure	Yes	No

Height_____ Weight_____

Kidney Disease	Yes	No
Liver Disease	Yes	No
Mitral Valve Prolapse	Yes	No
Nervous Problems	Yes	No
Respiratory Disease	Yes	No
Rheumatic Fever	Yes	No
Scarlet Fever	Yes	No
Seizures	Yes	No
Shortness of Breath	Yes	No
Sinus Trouble	Yes	No
Stroke, if yes when_____	Yes	No
Thyroid Problems	Yes	No
Tuberculosis	Yes	No
Weight Loss, unexplained	Yes	No
Do you wear contact lenses?	Yes	No
Do you pre-medicate **with antibiotic 1 hour** before dental procedures?	Yes	No
Do you smoke? _____	Yes	No
Do you drink alcohol? _____	Yes	No
Women: Are you pregnant?	Yes	No
Due date_____		
Are you nursing?	Yes	No
Are you trying to conceive?	Yes	No
Taking birth control pills?	Yes	No

Are you now or have you ever taken any of the bisphosphonate drugs marketed as: Zometa, Aredia, Boniva, Didronel, Fosamax, Reclast, Skelid ? Yes No If yes, please circle to indicate.

List any serious illnesses or injuries you have experienced:_____

_____ ☐ None

List any operations or surgeries you have had:_____

_____ ☐ None

Medications

List any medications you are currently taking and the correlating diagnosis:_____

_____ ☐ None

Pharmacy Name_____ Phone (___)_____

Allergies

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Local Anesthetic ☐ Latex ☐ Other_____

X_____

Signature of person completing medical history Dr's Initials

Updates **(To be filled in at future appointments)**

I have read my medical history dated ___/___/____ and confirm that it adequately states past and present conditions.

_____

Date Exceptions or Changes (or None) Patient's Signature Dr's Initials

Professional Endodontics *of Pinellas County, P.A.*

Margaret H. Young, D.D.S.

ENDODONTIC INFORMED CONSENT

We would like to welcome you to our office. It is important that you be informed about various procedures involved in Endodontic care. Informed consent is necessary before starting your treatment. Please take a moment to carefully read this form.

Endodontics is that specialty of dentistry which deals with cleaning, shaping, disinfecting and filling of root canals. The root canal refers to the space (or canal) inside the root of the tooth.

1. **Root canal therapy is about 95% successful. Many factors influence the treatment outcome**: the patient's general health, bone support around the tooth, strength of the tooth including possible fracture lines, shape and condition of the root and nerve canal(s), etc. It is a biological procedure that cannot be guaranteed.
2. **The tooth may normally be sensitive following appointments** and even remain tender for a time after treatment is completed. If sensitivity persists and does not seem to be getting better, even several weeks after the root canal is finished, please let the doctor know.
3. **Fractures are one of the main reasons why root canals fail**. Unfortunately, some cracks that extend from the crown down into the root are invisible and hard to detect. They can occur on uncrowned teeth from traumatic injury, biting on hard objects, habitual clenching or grinding or even just normal wear and tear. Whether the fracture occurs before or after the root canal, it may require extraction of the tooth.
4. Your dentist will recommend a crown to prevent future damage. If a permanent restoration is neglected, the tooth may be lost.
5. Teeth treated with root canals can still decay. As with other teeth, the proper care of these teeth consists of good home care, a sensible diet and periodic dental checkups.
6. With some teeth, conventional root canal therapy alone may not be sufficient. For example, if the canal(s) is severely bent or calcified, if there is substantial or long-standing infection in the bone around the roots, or if a metal file becomes separated within a canal, the tooth may remain sensitive and a surgery procedure, retreatment, or even extraction, may necessary to resolve the problem at additional costs.
7. **RISKS SPECIFIC TO ENDONDONTIC THERAPY**: Those risks include the possibility of instruments broken within the root canals, perforation(s) (extra opening) of the crown or root of the tooth, damage to bridges, existing fillings, crowns, fracture of porcelain, loss of tooth structure in obtaining access to the canals and cracked teeth. During treatment complications may be discovered which make treatment impossible or which may require endodontic surgery. These complications may include: blocked canals due to previous fillings or prior root canal treatment. natural calcification(s), broken instruments, curved roots, periodontal disease (gum disease), splits or fractures of the teeth.
8. **OTHER RISKS OF TREATMENT**: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics and injections. These complications include: swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, teeth and cheeks, which is transitory but on rare occasions may be a permanent reaction to injections, changes in occlusion (the bite), jaw muscle cramps and spasms. Temporomandibular joint (TMJ) difficulty, loosening of teeth, referred pain to the ear, neck and head, nausea, vomiting, allergic reactions, delayed healing, sinus perforations and treatment failure.
9. There are **alternatives to root canal therapy**. They include no treatment at all, extraction with nothing to fill the space, and extraction followed by a bridge or partial denture to fill the space.

Reviewed with patient_____

Please turn over to complete

I understand that root canal treatment is a procedure to retain a tooth, which may otherwise require extraction. I authorize the use of local anesthesia, medication, and/or additional procedures which the dentist may consider necessary or advisable during the course of the planned operations. Numbness about the corner of the mouth on the side of the tooth treated may develop. This is called "paresthesia" and is usually a temporary condition which will correct itself. It may persist for a few days to several months. Costs vary with the difficulty of treatment. I acknowledge full responsibility for the payment of such services and agree to pay for them in full. Charges for this procedure are payable at the first appointment. The patient is directly responsible for payment of services.

I certify that I have read and understand the above. I accept the risk of harm, if any, in hope of obtaining the desired beneficial result of this treatment. All of the above has been explained to me in a thorough manner and all questions about the treatment and its risks have been answered to my satisfaction. I give my consent to Dr. Margaret Young for the necessary treatment.

Tooth #_____

Signature of patient or legal guardian **X**_____ Date_____

Signature of doctor performing treatment _____

Signature of witness _____

****

FOR FUTURE USE

Tooth #_____

Signature of patient or legal guardian _____ Date _____

Signature of doctor performing treatment _____

Signature of witness _____

Tooth #_____

Signature of patient or legal guardian _____ Date _____

Signature of doctor performing treatment _____

Signature of witness _____

Professional Endodontics of Pinellas County, P.A.

CONSENT FOR USE AND DISCLOSURE OF HEALTH CARE INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: Home _____ **Cell** _____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing the consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Debbie
Phone: 727.384.4255 Fax: 727.384.4264 E-mail: proendo@tampabay.rr.com
Address: 509 Pasadena Avenue South, St Petersburg, FL 33707

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will notaffect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ **Date:** _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____