PATIENT INFORMATION

Name:_____ Referring Dentist:_____ Date:_____

Social Security No:_____ Date of Birth:_____ Age:_____

Cell #:_____ Home #:_____ Work #:_____

Preferred Contact: Home Cell Work

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Employer:_____

Name of Spouse, Parent, or Guardian:_____Phone:_____

DENTAL INSURANCE CARRIER

Plan Name:_____

ID #:_____Group #:_____

Name of Insured:_____ Relationship to Patient:_____

SSN of Insured:_____ DOB of Insured:_____

HEALTH HISTORY

1. Do you have any allergy to sensitivity to penicillin, erythromycin. Codeine, bleach, latex, Tylenol, aspirin, or any other medication or material?.....Yes No

   If so list allergies:_____

2. Have you ever had a reaction to an anesthetic injection?.....Yes No
3. Do you smoke or use tobacco products?.....Yes No
4. If female, are you pregnant or breast feeding?.....Yes No
5. Are you required to premedicate prior to dental procedures?.....Yes No

Please circle any of the following which you have presently or previously:

Heart Condition/Disease	Kidney Trouble	Cancer
Angina	Lung Disease	Chemo/Radiation
Congestive Heart Failure	Tuberculosis	Steroid Therapy
Artificial Heart Valve	Asthma	Seizures/Fainting
Irregular Heart Beat	Allergies/Sinus Trouble	Nervous System Disease
Heart Murmur	Diabetes	Anxiety/Depression/PTSD
Heart Pacemaker	Thyroid Disease	Chemical Addiction
Mitral Valve Prolapse	Anemia	Sleep Apnea
Bacterial Endocarditis	Prolonged Bleeding	Arthritis/Muscle/Joint Disease
Rheumatic Fever	Liver Disease	Artificial Joint
High Blood Pressure	Hepatitis (A B C D)	Pain in Jaw/TMJ
Stroke	AIDS/HIV	Artificial Implants/Devices
Organ Transplant	Stomach/Intestinal Disease	Osteoporosis Therapy

Do you have any disease, condition, or problem not listed? Yes No

If yes, please explain_____

Please list all surgeries/hosptializations_____

_____

Name of Primary Care Doctor and Specialists you see at least once a year_____

_____

I have answered these questions to the best of my knowledge.

Signature:_____Date:_____

Daniel J. Barton, D.M.D.

MEDICATION LIST

PATIENT NAME_____

PRIMARY CARE PHYSICIAN'S NAME & PHONE NUMBER_____

List **ALL** prescription and over-the-counter medications you are currently taking. Please include herbal medications, dietary supplements, and any medications you are taking for your tooth. **If you have a legible list of medications, we will gladly make a copy in place of filling out this form. Just sign below and attach list.**

Name of Medication	Dosage	How often do you take it?	What do you take it for?

❑ No medications

Signature_____ Date_____

Alliance Endodontics

Daniel J. Barton, D.M.D.

Informed Consent for Non-surgical Dental Treatment

1. **I consent to the necessary diagnostic procedures (including x-rays) to determine if root canal therapy is indicated. If root canal therapy is indicated, I will decide whether or not I wish to have treatment.**

2. **I understand that root canal treatment is an attempt to save a tooth that may otherwise require extraction. Although root canal therapy has a high degree of success, it is a dental-biological procedure whose results cannot be guaranteed. Occasionally, a tooth that has had root canal therapy may require retreatment, corrective surgery, or even extraction.**

3. **Treatment may require multiple visits. It is important that you maintain the scheduled appointments or infection and/or swelling may occur.**

4. **In most cases, there is only slight to moderate discomfort following each treatment. Severe post-treatment pain occurs in very few cases. This is usually controlled with Aspirin, Tylenol, Ibuprofen, or prescribed medications.**

5. **The most common complications with root canal therapy include, but are not limited to:**
   - **A. Continued infection, requiring endodontic surgery or extraction of the tooth.**
   - **B. Facial swelling requiring the use of antibiotics, surgical incision & drainage, or extraction of the tooth.**
   - **C. Calcified canals or canals blocked by broken instruments, requiring endodontic surgery or extraction of the tooth.**
   - **D. Pain, requiring the use of medication.**
   - **E. Side effects and reactions to medication such as allergies, nausea, vomiting, or diarrhea.**
   - **F. Fractures of the root or crown of the tooth during or after treatment. It is recommended that all posterior teeth be crowned following root canal treatment.**
   - **G. Fracture and loss of root canal treated tooth due to brittleness may be more likely to occur unless the tooth is restored.**
   - **H. If your tooth already has a crown, there is a chance it will need to be replaced due to decay or loss of structural support. Porcelain crowns are subject to break. Any crown may come off during treatment.**
   - **I. Tenderness of the tooth following treatment due to possible complications with root canal treatment, gum disease, physical stress of chewing, or the degree of healing your body exhibits.**

6. **Accurate and complete disclosure of medical information is necessary for proper diagnosis, and to help prevent unnecessary complications during your treatment. Some antibiotics may interfere with the effectiveness of oral contraceptives (birth control pills). Women who are taking contraceptives, and are given a prescription of an antibiotic, are strongly advised to use additional means of birth control during the entire monthly cycle.**

7. **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, loss of teeth, malocclusions, and infections to other areas.**

8. **Your referring dentist will advise you on the restorative phases of treatment and the financial investment involved.**

9. **It is your responsibility to contact your dentist for restoration of root canal treated tooth/teeth.**

10. **It is your responsibility to contact this office for follow-up visits.**

11. **The procedure(s) necessary to treat the condition(s) have been explained to me and I understand the nature of the procedure to be endodontic (root canal) therapy.**

My signature below indicates that I have read (or have had read to me) and understand this consent form. I have been given the opportunity to ask questions and all questions have been answered in a complete and satisfactory manner. This consent does not encompass the entire discussion I had with the doctor and his assistant regarding proposed treatment.

_____**DATE**_____

Patient's / Parent's Signature

_____ _____

Witness **Tooth/Teeth**

ALLIANCE ENDODONTICS

Daniel J. Barton, DMD, MS

Do you give our office permission to release medical information to your immediate family? Yes_____No_____

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

I understand it is MY responsibility to remove anyone from this list by notifying the office immediately.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

_____
Signature

_____
Date

TELL US ABOUT YOUR SYMPTOMS

PATIENT NAME_____

1. Are you having tooth/jaw pain today or have you had pain in the past year? Yes__ No__
   IF NO, PLEASE CONTINUE WITH QUESTION #4.
2. When did the pain start?_____
3. Can you locate the tooth that is causing the pain? Yes__ No__

Considering your pain <u>TODAY</u>, please select the following that most closely reflects the frequency, level and quality of your discomfort

Check All That Apply

FREQUENCY	LEVEL OF PAIN	QUALITY
__ Constant	__ Mild	__ Sharp
__ Intermittent	__ Moderate	__ Dull
__ Occasional	__ Severe	__ Throbbing
__ Spontaneous		__ Provoked

When eating or drinking, is your tooth sensitive to: Heat___ Cold___ Sweets___

Does your tooth hurt when you bite down or chew? Yes__ No__

Does it hurt if you press the gum tissue around this tooth? Yes__ No__

Does a change of posture (lying down or bending over) cause your tooth to hurt? Yes__ No__

Is there anything you can do to relieve the pain? Yes__ No__
If yes, what?_____

Is there anything you can do to cause the pain to increase? Yes__ No__
If yes, what?_____

4. Have you had a recent cold, allergies, or sinus problems? Yes__ No__
5. Do you grind or clinch your teeth? Yes__ No__
6. If yes, do you wear a night guard? Yes__ No__
7. Has a restoration (filling or crown) been placed on this tooth in the past six months? Yes__ No__
8. Prior to this appointment, has root canal therapy been started on this tooth? Yes__ No__
9. Is there anything else we should know about your teeth, gums or sinuses that would assist us in our diagnosis?_____

_____

Patient or Guardian Signature_____Date_____