LOWER GWYNEDD
ENDODONTICS

DENTAL REGISTRATION AND HEALTH HISTORY

Date_____

Patients Name_____How do you prefer to be addressed?_____

Sex: M F Age:_____Birth Date:_____/_____/_____ SS#_____-_____-_____

Mailing Address_____City_____State_____Zip_____

Home #:_____Cell#:_____Work#: _____

Employer:_____Occupation: _____

If Student, name of School / College:_____City_____State_____Part Time or Full Time

Email Address:_____Whom may we thank for referring you to our office:_____

If the person responsible for this patients account is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled "Insurance Information"

Name of responsible party_____Relationship to Patient_____

Mailing Address_____City_____State_____Zip_____

Sex: M F Age:_____Birth Date:_____/_____/_____ SS#_____-_____-_____

Home #:_____Cell#:_____Work#:_____

Email Address:_____Employer:_____Occupation:_____

INSURANCE INFORMATION

Policy Holders Name_____Relationship to Patient_____

Social Security and/or Member ID #_____Date of Birth_____/_____/_____

Name of Employer_____Employer Address_____

Insurance Co._____Phone #_(_____)_____-_____Group #_____

Secondary Insurance Information

Policy Holders Name_____Relationship to Patient_____

Social Security and/or Member ID #_____Date of Birth_____/_____/_____

Name of Employer_____Employer Address_____

Insurance Co._____Phone #_(_____)_____-_____Group #_____

Answers to the following questions are for our records only and will be considered confidential.

ALLERGIES

Aspirin	Local Anesthetic
Barbiturates	Penicillin
Codeine	Sulfa
Iodine	Metals
Latex	Other:_____

MEDICATIONS

Please list any medications you are currently taking:

_____

_____

_____

_____

Place a mark on YES or No to indicate if you have had any of the following:

Chest Pain	YES	NO	Hepatitis A (Infectious)	YES	NO	Use of tobacco products	YES	NO
Heart Failure	YES	NO	Hepatitis B (Serum)	YES	NO	Drug addictions	YES	NO
Heart Disease or Attack	YES	NO	Hepatitis C or other	YES	NO	Alcoholism	YES	NO
Osteoprosis/osteopenia	YES	NO	Tuberculosis (TB)	YES	NO	Psychiatric Treatment	YES	NO
Heart Surgery	YES	NO	HIV positive, ARC, AIDS	YES	NO	Bisphosphonate	YES	NO
*Mitral Valve Prolapse	YES	NO	Sickle Cell Disease	YES	NO	Birth Defects	YES	NO
*Congenital Heart Problems	YES	NO	Emphysema	YES	NO	Eating Disorder	YES	NO
*Heart Murmur	YES	NO	Diabetes	YES	NO	Fainting or dizzy spells	YES	NO
High Blood Pressure	YES	NO	Liver Disease	YES	NO	Epilepsy or seizures	YES	NO
Heart Pacemaker	YES	NO	Thyroid Disease	YES	NO	Persistent Cough	YES	NO
Stroke	YES	NO	Kidney Trouble	YES	NO	Asthma	YES	NO
Cancer (Type:	) YES	NO	Hemophilia	YES	NO	Shortness of Breath	YES	NO
Radiation Therapy	YES	NO	Jaundice	YES	NO	Hay Fever	YES	NO
Chemotherapy	YES	NO	Anemia	YES	NO	Hives or Skin Rash	YES	NO
*Steroid Treatment	YES	NO	Glaucoma	YES	NO	Sinus Trouble	YES	NO
*Artificial Joints	YES	NO	Arthritis	YES	NO	Herpes	YES	NO
*Any Type of Transplant: Type	YES	NO	Ulcers	YES	NO	Cold Sores	YES	NO
*Any Type of Implant: Type	YES	NO	Angina Pectoris	YES	NO	Bruise Easily	YES	NO
*Rheumatic Fever	YES	NO	Blood Transfusion	YES	NO			

OTHER:_____

*Antibiotic pre-medication may be required prior to your appointment

Have you been advised by your Physician to "Pre-Medicate" for dental appointments? YES NO

WOMEN: Are you pregnant now?	YES	NO	If yes, what is your due date?_____
Are you currently breast feeding?	YES	NO	
Are you taking oral contraceptives?	YES	NO	

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/ or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

*Signature of patient or guardian*_____

_____

Signature of Dentist

Date:_____

Discussion and Informed Consent for Root Canal Treatment/ Retreatment

First and Last Name ----------

Facts for Consideration

Patient's initials required.

_____ Root canal treatment, also called *endodontic treatment,* involves removing the nerve tissue (called *pulp*) located in the center of the tooth and its root or roots (called the *root canal*). Treatment involves creating an opening through the biting surface of the tooth to expose the remnants of the pulp, which are then removed. Medications may be used to disinfect the interior of the tooth to prevent further infection. Root canal treatment may relieve symptoms such as pain and discomfort. Twisted, curved, accessory or blocked canal(s) may prevent removal of all of the inflamed or infected pulp. The presence of any residual pulp in the canal(s) may cause your symptoms to continue or worsen. This might require an additional procedure called an *apicoectomy*. A small opening is cut in the gums and surrounding bone; any infected tissue is removed, and the canal(s) is sealed. An apicoectomy may also be required if your symptoms continue and the tooth does not heal.

_____ Each empty tooth canal(s) that can be located is filled with a material designed specifically for root canal therapy. Sometimes a canal is present but cannot be located. Occasionally, a post is also inserted into the canal to help secure restorations of the tooth. After filling through the opening in the tooth, the tooth is closed with a temporary filling. At a later appointment, a permanent filling or *crown* may be placed. This is a separate dental procedure not included in this discussion. Once the root canal treatment/ retreatment is completed, it is essential to return promptly to begin the next step in treatment. Because a temporary seal is designed to last only a short time, failing to return as directed to have the tooth sealed permanently with a crown or filling can lead to other problems, such as the need to repeat the treatment at an additional cost and deterioration of the seal, resulting in decay, infection, gum disease, fracture and the possible loss of the tooth. Failure to restore a root canal treated tooth may result in fracture and loss of the tooth. Even in cases with no complications where a crown or filling is placed right away, this procedure will not prevent future tooth decay, tooth fracture or gum disease and occasionally a tooth that has had root canal treatment may require endodontic retreatment (repeat), endodontic surgery or tooth extraction.

Benefits of Root Canal Treatment/ retreatment, Not Limited to the Following:

____ Root canal treatment/ retreatment is intended to extend the lifespan of your tooth, which will help to maintain your natural bite and the healthy functioning of your jaws. This treatment may also be recommended to relieve the symptoms that may be associated with the diagnosis described above.

Risks of Root Canal Treatment/ retreatment, Not Limited to the Following:

____ I understand that following treatment I may experience bleeding, pain, swelling and discomfort for several days, which may be treated with pain medication. It is possible infection may accompany root canal treatment and may require treatment with antibiotics. I will immediately contact the office or my dentist if my condition worsens or if I experience fever, chills, sweat, numbness, sinus problems, severe pain or swelling. I understand that I may receive a local anesthetic (numbing agent) by injection and/or other medication. In rare instances, patients may have a reaction to the anesthetic such that it reduces one's ability to control swallowing, which may require emergency medical attention. This increases the chance of swallowing foreign objects during treatment. **Depending on the anesthesia and medications administered, I may need a designated driver to take me home.** Rarely, temporary, or permanent nerve injury to the face or oral cavity can result from an injection of local anesthesia resulting in numbness of the lip, chin, gums, teeth, and cheek and possibly loss of the sense of taste. I understand that all medications have the potential for accompanying risks, side effects and drug interactions. Therefore, it is critical that I tell my dentist of all medications and supplements I am currently taking. I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days; this is sometimes referred to as trismus. However, this can occasionally be an indication of a more significant condition or problem. In the event this occurs, I must notify this office if I experience persistent trismus or other similar concerns arise.

____ I understand that occasionally a root canal instrument may separate in a root canal that is twisted, curved, or blocked with calcium deposits. Depending on its location, the fragment may be retrieved or it may be necessary to seal it in the root canal (these instruments are made of sterile, nontoxic surgical stainless steel and typically cause no harm). It may also be necessary to perform an apicoectomy as described above to seal the end or lower part of the root canal. I understand that during treatment the root canal filling material may extrude out the root canal into the surrounding bone and tissue. Occasionally, an apicoectomy may be necessary for retrieving the filling material and sealing the root canal. I understand that other complications which may occur include, but are not limited to, perforations (extra openings) of the canal made by an instrument, perforation of the sinus cavity, blocked root canals that cannot be completely cleaned and filled, fracture, chipping or loosening of existing adjacent tooth or crown requiring replacement at an additional cost and temporary or permanent numbness or painful nerve sensations.

____ I understand teeth that have received root canal treatments may become brittle and be more prone to cracking and breaking over time, particularly if the crown is not restored with a large filling or artificial crown, which may require removal and replacement with a bridge, partial denture, or implant. In some cases, root canal treatment may not relieve all symptoms. The presence of gum disease (*periodontal disease*) can increase the chance of losing a tooth even though root canal treatment was successful. There is no guarantee of success. I understand that root canal treatment may not relieve my symptoms, and I may need my tooth extracted.

Consequences if No Root Canal Treatment/ retreatment Is Administered, Not Limited to the Following:

_____ I understand that if I do not have root canal treatment/ retreatment, my discomfort may continue and I may face the risk of a serious, potentially life-threatening infection, abscesses in the tissue and bone surrounding my teeth and eventually the loss of my tooth and/or adjacent teeth.

Alternative Treatments if Root Canal Treatment/ Retreatment Is Not the Only Solution, Not Limited to the Following:

I understand that depending on my diagnosis, alternatives to root canal treatment may exist that involve other disciplines in dentistry. Extracting my tooth is the most common alternative to root canal treatment. It may require replacing the extracted tooth with a removable or fixed bridge or an artificial tooth called an *implant.* I have asked my dentist about the alternatives and associated expenses. My questions have been answered to my satisfaction regarding the procedures, its risks, benefits, alternatives, and cost.

Alternatives discussed: Yes

No guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.

Consent

I have been informed both verbally and by the information provided on this form of the risks and benefits of the proposed treatment.

I have been informed both verbally and by the information provided on this form of the material risks and benefits of alternative treatment and of electing not to treat my condition.

I certify that I have read and understand the above information and that the explanations referred to are understood by me, that my questions have been answered and that the blanks requiring insertions or completion have been filled in. I authorize and direct Dr. Nasim Levin/ Dr. Bryan Stein to do whatever he/she deems necessary and advisable under the circumstances.

I consent to have the above-mentioned treatment.

While the treatment may be covered by my medical and/or dental insurance, I accept any financial responsibility for this treatment and authorize treatment.

Patient or Patient's Representative

Date

Witness Signature

Date

I attest that I have discussed the risks, benefits, consequences, and alternatives of the above treatment with _____ (Patient or Patient's Representative) and they have had the opportunity to ask questions. I believe they understand what has been explained and consent or refuses treatment noted above.

Dentist Signature

Date