West GA Endodontics

REGISTRATION FORM

Patient's Name _____

Date of Birth_____ Social Security Number_____

Address _____

Street City State Zip Code

Cell phone # _____ Alternate # _____

Email Address _____

Emergency contact name and number _____

If patient is a minor:

_____

Person responsible for account DOB SSN Phone Number

FINANCIAL AGREEMENT

Please check one:

- **I have dental insurance:**

  If you would like to know whether or not we are an in-network provider with your insurance, please speak with the front office coordinator PRIOR to treatment.

  If you are scheduled for *endodontic therapy (root canal treatment),* we have verified your insurance coverage and *have estimated* your out of pocket expense. The estimated portion is due in full at the time of treatment. We will file your dental insurance for you.

  If you are scheduled for a *consultation* appointment, the consultation fee is due in full at the time of the consultation visit. We will file your insurance for your reimbursement.

- **I do not have dental insurance:**

  Payment is due in full for all dental services and consultations.

*****I have read and understand the financial policy for West GA Endodontics*****

Signature_____ Date_____

West GA Endodontics

Medical History

Patient Name _____Referring Dentist _____

Primary Care Physician _____ Are you under a physician's care now? _____

Do you premedicate prior to dental procedures? (Check One) YES_____ NO_____

Please check all that apply to you:

- Heart trouble/surgery/angina
- High blood pressure
- Heart murmur
- Rheumatic fever
- Artificial heart valve
- Artificial joint
- Kidney disease
- Cancer/tumors
- Radiation/chemotherapy
- Lung disease
- Tuberculosis (TB)
- Epilepsy
- Diabetes
- AIDS/HIV
- Hepatitis/liver disease
- Hemophilia/ excessive bleeding
- Drug addiction
- Sexually transmitted disease
- Herpes
- Psychiatric/mental disorder
- Asthma
- Allergies/sinus trouble

Do you take any medications on a daily basis? _____

If so, please list medication(s):

_____

Are you pregnant? _____ How many months? _____ Breastfeeding child? _____

Are you allergic or have you ever had an allergic or unusual reaction to the following medications?

- Dental local anesthetics
- Aspirin
- Tylenol compounds
- Codeine/other narcotics
- Penicillin
- Erythromycin
- Sulfa drugs
- Latex
- Any other antibiotics?

  _____
- Any other medications?

  _____

To the best of my knowledge, all of the preceding answers are true and correct. If I have any changes in my health, or if my medications change, I will inform the treating doctor.

_____ _____

Patient signature (parent or guardian if minor) Date

West GA Endodontics

NAME_____

CONSENT TO ENDODONTIC THERAPY

Please review the following consent. You will be required to sign it prior to the initiation of treatment; however, it does not commit you to treatment.

This is my consent to the endodontic procedures indicated and any other procedures deemed necessary or advisable as a corollary to the planned endodontic therapy performed by any of the endodontists, and any assistant he/she may require. I agree to the use of local anesthesia, depending upon the judgment of the endodontist. I understand the endodontist will consult with me prior to administering any sedation. **Complications of root canal therapy and anesthesia may include swelling, pain, trismus (restricted jaw opening), infection, bleeding, sinus involvement, and numbness or tingling of the lip, gum or tongue, which rarely is protracted and even more rarely is permanent. I understand that it is my responsibility to report any symptoms to the endodontist immediately.**

I understand that root canal therapy is a procedure to retain a tooth which may otherwise require extraction and that as a specialty practice, the office performs only endodontic therapy and associated surgery. Although root canal therapy has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery, or even extraction. Following treatment, the tooth may be brittle and subject to fracture. A restoration (filling), crown and/or post and core will be necessary to restore the tooth to function; this will be performed by my dentist. During treatment there is the possibility of: instrument separation within the root canals, perforations (extra openings), damage to bridges, existing fillings, crowns, porcelain veneers, missed canals, loss of tooth structure in gaining access to canals, and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when my tooth may not be amenable to endodontic treatment at all. Other treatment choices include no treatment, waiting for more definitive symptoms to develop, or tooth extraction. Risks involved in these choices might include, but are not limited to: pain, infection, swelling, loss of the tooth, and infection to other areas.

At times, medication will be prescribed by the endodontist. I understand that medications for discomfort and sedation may cause drowsiness, which can be increased by the use of alcohol or other drugs. I am advised against the use of alcohol or operating any vehicle or hazardous devices while taking such medications. I further understand that certain medications may cause hives and/or intestinal problems and if any of these reactions occur, I am to call the endodontist immediately. I understand that it is my responsibility to report any changes in my medical history to the endodontist.

It has been explained to me and I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted. I have been given the opportunity to question the doctor concerning the nature of the treatment, the inherit risks of the treatment, and the alternative to this treatment.

PLEASE DO NOT WRITE IN THE SPACE BELOW IF YOU HAVE ANY QUESTIONS FOR DR. GREEN

If there is anything that you do not understand about the endodontic procedure, or any statements in this form, or if you still have any questions after reading this form, please ask the doctor before treatment is started.

_____ _____ _____ _____

Date Procedure Signature Doctor

*Signature must be by a parent or guardian if the patient is under the age of 18.

WEST GA ENDODONTICS

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I may receive a copy of the Notice of Privacy Practices from West Georgia Endodontics, which sets forth the ways in which my personal health information may be used or disclosed by West Georgia Endodontics, and outlines my rights with respect to such information by **asking for a copy at the front desk.**

Signature_____Date_____