PATIENT INFORMATION

NAME_____
Last First

ADDRESS_____
Number and Street City State Zip

HOME PHONE_____ CELL PHONE_____

DATE OF BIRTH_____ AGE _____ GENDER: M or F (Circle)

EMPLOYER_____ WORK PHONE_____

OCCUPATION_____

EMERGENCY CONTACT_____ PHONE_____
Name Relationship

FAMILY DENTIST_____

WHO MAY WE THANK FOR YOUR REFERRAL? _____

DENTAL INSURANCE

PRIMARY CARRIER: Self Spouse Other

INSURANCE CO_____ ADDRESS _____

PHONE NUMBER _____ ID #_____ SSN#_____

If not self, POLICY HOLDER _____ SSN#_____DOB_____

SECONDARY CARRIER: Self Spouse Other

INSURANCE CO_____ ADDRESS _____

PHONE NUMBER _____ ID#_____

POLICY HOLDER _____ SSN#_____DOB_____

MEDICAL/DENTAL HISTORY

Accurate and complete disclosure of medical information is necessary for proper diagnosis and to prevent unnecessary complications during your treatment.

PHYSICIAN_____PHONE_____

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart attack When?_____
- ☐ Heart pacemaker
- ☐ Heart surgery
- ☐ Irregular heart beat
- ☐ Heart murmur Premed?_____
- ☐ Mitral valve prolapse Premed?_____
- ☐ Rheumatic fever Premed?_____
- ☐ Angina/Chest pain When last?_____
- ☐ Congenital heart defect

DERMAL/MUSCULOSKELETAL

- ☐ Sore jaw muscles/joints
- ☐ Arthritis
- ☐ Artificial joints Premed?_____
- ☐ Mouth ulcers/Sores
- ☐ Bisphosphonates: Fosamax, Acetonel, Aredia, Boniva, Zometa, Didronel

NERVES & SENSORY

- ☐ Severe headaches
- ☐ Fainting/Dizzy spells
- ☐ Epilepsy/seizures
- ☐ Nervousness
- ☐ Dental anxiety

RESPIRATORY

- ☐ Sinus Problems
- ☐ Allergies or hives
- ☐ Asthma
- ☐ Use inhaler How often?_____
- ☐ Tuberculosis (TB)

OTHER CONDITIONS

- ☐ Parkinsons
- ☐ Enlarged node/gland
- ☐ Endocrine (hormonal)
- ☐ Diabetes Take insulin?_____
- ☐ Thyroid disease
- ☐ Use tobacco
- ☐ Use alcohol
- ☐ Drug dependency
- ☐ Tumor/cancer
- ☐ Radiation/chemotherapy

GASTROINTESTINAL

- ☐ Ulcers/GERD
- ☐ Liver disease
- ☐ Cirrhosis
- ☐ Irritable bowel syndrome

HEMATOLOGIC (BLOOD)

- ☐ Stroke When?_____
- ☐ Anemia
- ☐ Prolong bleeding
- ☐ Leukemia
- ☐ HIV/AIDS
- ☐ Blood transfusion
- ☐ Take daily Aspirin
- ☐ Blood thinners Coumadin/Warfarin
- ☐ Hepatitis When?_____ What type?_____

URINARY

- ☐ Urinate frequently
- ☐ Kidney problems
- ☐ Dialysis

ALLERGIES

Are you allergic to any of the following?

- ☐ Penicillin, Amoxicillin, Augmentin
- ☐ Asprin, Advil, Motrin, Ibuprofen
- ☐ Sulfa/sulfites
- ☐ Other: _____
- ☐ Valium or other tranquilizers
- ☐ Local anesthetic (novocaine, adrenaline)
- ☐ Codeine or other narcotics
- ☐ Latex

Please list any medications you are currently taking:

Please list any other medical conditions or concerns not mentioned above that the doctor should be aware of:

Have you seen a physician for a medical condition in the last 6 months? YES _____ NO_____
If so, please list: _____

Have you ever had root canal treatment before? YES _____ NO _____
Have you ever had a reaction to dental anesthetic? YES _____ NO _____

WOMEN: Are you pregnant? YES _____ NO_____ How far along? _____months
Are you currently taking any birth control pills, hormones, etc.? _____

**If you are taking birth control pills, please be advised that if you take antibiotics, it can make the birth control pills less effective and an alternate method of birth control may be necessary for 30 days after completion of the antibiotic regimen.*

Please notify our office of any change in your health information or abnormal laboratory test result at your next appointment.

To the best of my knowledge, all the preceding answers are true and correct.
Patient or Guardian Signature_____ Date_____

ENDODONTIC CONSENT

Endodontic (Root canal) Therapy, Endodontic Surgery, Anesthetics and Medications

Endodontic therapy is performed in order to save a tooth which otherwise would need to be removed (pulled). Root canals are performed on teeth that are infected, teeth with large fillings, teeth that are improperly placed, or teeth in which the untreated nerve will cause pain or an abscess. This is accomplished by removing the soft tissue (pulp) within the tooth and replacing it with an inert sealing material in each root of the tooth. In some cases, endodontic surgery at the root tip may save teeth that would be lost. These treatments do not lower the risks for gum disease or new decay. **There is no guarantee that treatment will be successful.**

GENERAL RISKS: General risks include, but are not limited to, complications resulting from the use of dental instruments, drugs, bleeding, pain, infection, numbness, tingling in the lip, tongue, chin, gums, cheeks or teeth which is usually temporary, but can on infrequent occasions be permanent. Other general risks include reactions to injections, changes in occlusions (biting), jaw muscle cramps and spasms, jaw joint difficulty, loosening of teeth, referred pain to ear, head or neck, vomiting, nausea, allergic reactions, delayed healing, cyst formation, chronic infections, sinus perforation and treatment failure.

RISKS SPECIFIC TO ENDODONTIC THERAPY: Specific risks include the possibility of instruments broken within the root canals; perforations (extra openings) of the crown or root of the tooth; damage to bridges, existing filings, crowns, or porcelain veneers; loss of tooth structure gaining access to canals, and/or cracked teeth. Incomplete healing of the infection or treatment complications may be discovered which makes treatment impossible, such as natural calcifications, broken instruments, incomplete or excessive filling material, curved roots, periodontal disease (gum disease), splits or fractures of the teeth. Not all teeth have the same degree of risks.

MEDICATIONS: It is not advisable to operate any vehicle or hazardous device until recovered from their effects, or to make important decision while taking medications.

OTHER TREATMENT OPTIONS: Options to endodontic therapy include no treatment, waiting for more definite development of symptoms, or tooth extraction. Risks involved in these choices include pain, infection, swelling, loss of teeth, and infection in other areas.

CONSENT:

1. I, the undersigned, being the patient (parent or guardian of minor patient) consent to the performing of procedures decided upon as necessary or advisable in the opinion of Dr. Bishop.
2. I understand that upon completion of the root canal, I shall return to my general dentist for a permanent restoration of the tooth involved, such as a crown, porcelain veneer, onlay, or filling within 30 days unless otherwise instructed. **This must be completed, or you will increase the risk of complications and loss of the tooth.**
3. 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 cannot be guaranteed**. Occasionally, a tooth that has had root canal therapy may require retreatment, surgery, or even extraction.

Patient or Guardian Signature_____Date_____

INFORMATION DISCLOSURE CONSENT (HIPPA)

By signing below, you consent to the use and disclosure of your protected health information by Frank D. Bishop, Jr., DMD, PC, our staff and our business associates ***for treatment, payment and healthcare operations***. For a more detailed description of uses and disclosures for these purposes, please ask to review our Notice of Information Practices ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this notice may change. If the terms do change, you may obtain a revised Notice by contacting this office at 706-769-7106 and requesting a revised notice. We will also post any revised notice in the waiting room.

You have the right to request that we restrict our uses and disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and healthcare operations, although we are not required to agree to your requested restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information.

Patient or Guardian Signature _____Date_____