PATIENT INFORMATION (please print) **Date**

Last _____ **First** _____ **M.I.** _____

Date of Birth / / **Age** _____

Address _____
street apt. city state zip

Phone(s) _____ _____ _____
Home Work Cell

Employer _____ _____-_____-_____
Social Security Number

Occupation _____

Responsible Party (if different from above)

Last _____ **First** _____ **M.I.** _____

Employer _____ **Date of Birth** / /

_____-_____-_____ _____
Social Security Number Address (if different from above)

In case of emergency, please notify:

Last Name _____ First Name _____ M.I. _____

Relationship to Patient _____ Phone _____

General Dentist _____ **City** _____

Referred by (if different than above) _____

Visit our Website at www.endoprofessionals.com

All Information is Kept Strictly Confidential and Is Not Released For Any Reason Without Your Expressed Consent Except For the Purposes of Carrying Out Health Care Operations As Described In Our Office's Notice of Privacy Practices

Health History patient name:_____

Are you (or the patient) now or in the past 5 years, been under the care of a physician/medical doctor, including hospitalization(s) and surgery? Please detail:

_____

_____

_____

Medications prescribed or over the counter (including herbal/recreational) taken in the past 30 days:

_____

_____

_____

Allergies or sensitivities to medications or materials, including latex:

_____

_____

_____

Please circle if you now have or have ever been treated for any of the following conditions:

Heart Disease/Defects	**Kidney Disease**	**Cancer**
Heart Attack	**Liver Disease**	**Seizures**
Heart Surgery/Stents/Bypass	**Ulcer/GI Disease**	**Glaucoma**
Heart Murmur/Replaced Valve	**Blood Pressure**	**Diabetes**
Irregular Heart Beat	**Tuberculosis**	**Neurologic Condition**
Pacemaker/Defibrillator	**Hepatitis**	**Immune Deficiency/HIV**
Angina/Chest Pains	**Chemical Dependency**	**Tobacco Use**
Fainting/Dizziness	**Thyroid/Adrenal**	**Sleep Apnea**
Prolonged Bleeding	**Stroke**	**Currently Pregnant/Nursing**
Asthma	**Replaced Joint**	**Bisphosphonates/Osteoporosis**

Approximate date of your last medical exam (physical) _____ **Month/Year**

Please detail any of the above as needed or inform us of anything else you feel we should know about including problems with prior dental treatment:

_____

_____

To the best of my knowledge, I have answered all parts completely and accurately. I will inform my dentist of changes in my health or medications.

Patient Signature _____ **Date** _____

Parent or guardian signature if patient is under 18 years of age

☐ **Premedication Needed** **Doctors Initials** _____

ENDODONTIC PROFESSIONALS, P.A.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

affix patient chart label here

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, of 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 this 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 sending a written request to: Privacy Officer, Endodontic Professionals, P.A., 12000 Elm Creek Blvd, Suite 240, Maple Grove, MN 55369.

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 Privacy Officer at the address listed above. Please understand that revocation of this Consent will not affect 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 heath care operations.

X 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: _____

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: _____

ENDODONTIC PROFESSIONALS, P.A.

INFORMATION AND CONSENT FOR ENDODONTIC TREATMENT

PATIENT

ENDODONTIC ROOT CANALTHERAPY, ENDODONTIC SURGERY, ANESTHETICS, AND MEDICATIONS

We would like our patients to be informed about the various procedures involved in endodontic therapy and have their consent before starting treatment. Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by conservative root canal therapy, or when needed, endodontic surgery. The following discusses possible risks that may occur from endodontic treatment, and other treatment choices.

GENERAL RISKS: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and inject ions. These complications include: swelling; sensitivity; bleeding; pain ; infection; numbness and tightening sensations in the lip, tongue, chin, gums, cheeks and teeth, which is transient but on rare occasions may be permanent; reaction to injections; changes in occlusion (biting); jaw muscle cramps and spasms; temporomandibular (jaw) joint difficulty; loosening of teeth; referred pain to ear, neck and head; nausea; vomiting; allergic reactions; delayed healing; sinus perforation; and treatment failures .

RISKS MORE SPECIFIC TO ENDODONTICS THERAPY: The 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 fillings, crowns or porcelain veneers; loss of tooth structure in gaining access to canals; and cracked teeth. During treatment, complications may be discovered which make treatment impossible, or which may require dental surgery. These complications may include: blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), splits or fractures of the teeth.

MEDICATIONS: Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be enhanced by the use of alcohol, tranquilizers, sedatives or other drugs). **It** is not advisable to operate any vehicle or hazardous device until recovered from their effects. Use of antibiotics may inhibit the effectiveness of oral contraceptives.

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

CONSENT: I, the undersigned, being the patient (parent or guardian of above minor patient) consent to the performing of examination, tests, and procedures decided to be necessary or advisable in the opinion of the doctor. I also understand that upon completion of root canal therapy in this office, I shall return to my general dentist for a permanent filling of the tooth involved, such as a crown, cap, onlay, or silver or white filling.

I understand that root canal treatment is an attempt to save a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require treatment, surgery, or even extraction.

I also agree to accept financial responsibility, including all reasonable collection costs such as court, legal and collection fees and interest at 1 1/2% per month on all balances over 60 days , for payment of the account as a result of treatment rendered to the above named patient.

DATE	PATIENT SIGNATURE (PARENT/GUARDIAN)	DOCTOR'S SIGNATURE