ROOT CANAL DENTISTS

A root canal practice accepting
Medicaid/CHIP/most PPO Insurance

MEDICAL AND PERSONAL HISTORY

Last First MI Today's Date_____

Name_____ Age_____ Mr. Mrs Ms Dr

Address_____ Home Phone_____

City, State, Zip_____ Work Phone_____

Sex: M F Patient SS#_____ Cell Phone_____

Date of Birth___/___/____ Responsible Party_____ Referring Dentist_____

Employer _____ Current Position_____

Dental Insurance Carrier_____ Group #_____

Employer that Carries Benefits_____

Medical History Circle all that applies, present and past

Date of Last Medical Exam _____

Heart Trouble	Lung Disease	Stroke	Hepatitis A	Asthma
High Blood Pressure	Tuberculosis	Anemia	Hepatitis B	Sinus Trouble
Heart Murmur	Kidney Trouble	Diabetes	Jaundice	Liver Disease
Heart Valve Problem	Allergy or Hives	Hemophilia	Epilepsy	Seizures
Drug Addiction	Mitral Valve Prolapse	Thyroid Disease	TMJ Pain	Rheumatic Fever
Blood Transfusion	Bleeding Problem	Latex Allergy	AIDS/ HIV+	Heart Pacemaker
Cortisone Therapy	Cancer/Leukemia	Chemotherapy	Artificial Joint	Venereal Disease

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

Please list_____

*** Are you allergic to any medication or anesthetic injection?** **Yes** **No**

Please list medications and reaction_____

_____

*** Do you routinely need antibiotics before dental treatment?** **Yes** **No**

Please list the name and amount of antibiotic you usually take_____

*** Are you under the care of a physician now?** **Yes** **No**

If yes, for what?_____

*** If female, are you pregnant, breast-feeding, or taking oral contraceptives?** **Yes** **No**

Please list ALL medications, vitamins, and supplements taken in the last 3 days, with dosages. (Include Aspirin, herbal supplements, oral contraceptives, etc.)

_____

_____

Family Physician's Name _____ Phone #_____

Preferred Pharmacy_____ Phone #_____

Person to contact in case of emergency _____ Phone #_____

I have answered these questions truthfully and accurately. Should subsequent visits occur I agree to inform my treating Doctor of any changes in my health status, medication, address or phone numbers, or insurance information. I understand that failure to disclose medical and medication history may result in the immediate termination of doctor/patient relationship at the discretion of Root Canal Dentists.

*Patient Signature*_____ *Date*_____

*Doctor Initials*_____

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Guardian Agreement

To best respond to the needs of your child, we offer two choices. Please check one of the following:

- ☐ **If you wish to remain in the treatment room, we encourage you to be a silent helper. By choosing this option, you understand that you will not interfere with the doctor, assistant, or child while treatment is being performed, no cell phone use and must remain seated throughout the whole treatment. If you are not able to comply, you will be asked to leave the room or treatment will be stopped.**

- ☐ **If you are not comfortable or think that your child will do better alone, please remain in the waiting room.**

- ❖ **A parent or legal guardian must remain in the office during treatment at all times.**

I (We) have read the above and was/were given the opportunity to ask additional questions. I (we) freely give my (our) informed consent.

Patient Name: _____ Date of Birth: _____

Guardian's Signature: _____ Contact #:_____

Printed Name: _____ Relationship: _____

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Consent for Treatment with Oral Conscious Sedation

In order to provide dental treatment for _____, it is necessary to prescribe/administer a sedative medication prior to treatment. This medication is intended to relax your child and allow the dentist to provide treatment safely and effectively.

The medication/s to be used is/are: _____The patient's weight is: _____lb.s

- Treatment options have been explained and include no treatment, passive and/or active restraints, oral conscious sedation and a combination of Nitrous Oxide/Oxygen(laughing gas) inhalation sedation. Your doctor recommended the option listed above.
- Any treatment involving nitrous oxide and/or oral sedation require the child not eat or drink anything three hours prior the administer of the medication or treatment. Failure to comply with not eating or drinking will lead to cancellation of the appointment and possible charges. Patients who do eat or drink are at greater risk of aspiration and complications.
- Sedative medications are intended to calm and quiet your child, **not to make your child unconscious or asleep**. At different times, your child may be hyperactive, irritable, drowsy, or asleep. Crying is expected at different times when your child is stimulated during the appointment.
- Nitrous oxide is usually administered in addition to the sedative medication, to help calm your child. It does not put your child to sleep. However, many children become so relaxed that they may nap. Pregnant woman and small infants are not permitted in the treatment room when nitrous oxide is used for safety precautions.
- Local anesthetic (numbing) will be administered to prevent discomfort.
- The use of sedation medication is a risk to your unborn baby and is contraindicated during pregnancy due to possibility of sudden miscarriage.
- Dental treatment has potential risks and consequences. Likewise, so does the refusal or denial of dental treatment. Untreated decay may lead to pain, swelling, infection and tooth loss. Risks involved with treatment include allergic reactions to medications, filling materials, and latex. Prolonged anesthesia may occur.
- To best respond to the needs of your child, we offer two choices: If you wish to remain in the treatment room, we encourage you to be a **silent helper**. By choosing this option, you understand that you will not interfere with the doctor, assistant, or child while treatment is being performed. If you are not able to comply, you will be asked to leave the room or treatment will be stopped. If you are not comfortable or think that your child will do better alone, please remain in the waiting room. **A parent or legal guardian must remain in the office during treatment at all times.**
- Patients undergoing sedation are subject to the risk of medical complications including, but not limited to: nausea and vomiting, prolonged numbness, secondary infection, post-operative swelling, allergic reactions, and in deep sedation, respiratory and cardiovascular problems.

I understand and have had ample opportunity to discuss all of the above information. My questions have been fully answered, and I request treatment with oral conscious sedation.

Patient Signature _____ **Date**_____

Printed Name _____

_____ Check if you are the parent or guardian of the named patient (if patient is under 18 y.o.)

Guardian's Signature_____ **Contact #:**_____

Printed Name _____ **Relationship**_____

Doctor's Signature _____ **Assistant's Signature** _____

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Nitrous Oxide/ Oxygen Inhalation Sedation Patient Consent Form

To help lower your anxiety during dental treatment and contribute in making your appointment(s) more pleasant, inhalation (breathing) sedation using a combination of nitrous oxide (sometimes called laughing gas) and oxygen (hereafter N_2O) is available. Typically most patients find the nitrous oxide to be effective at controlling their anxiety with little to no ill effects. However, in some cases, the level of effectiveness can be unpredictable and in rare cases patients may experience undesirable reactions to N_2O despite our best efforts to minimize this from happening. These problems include – but are not limited to – nausea and vomiting, allergic reactions, breathing problems, heart problems and blood pressure problems. On very rare occasions, patients have had to be hospitalized with a life- threatening problem.

FEMALES:
If you suspect you are pregnant, it is critical that you inform us immediately! The use of N_2O is a possible risk to your unborn baby; therefore we advise AGAINST the use N_2O during pregnancy. There is a risk for sudden miscarriage or loss of the baby if you use nitrous oxide during your pregnancy.

I understand that I should not eat or drink 4 hours prior to using N_2O to reduce the possibility of undesirable reactions mentioned above, particularly nausea and vomiting.

I (We) have read the above and was/were given the opportunity to ask additional questions. I (we) freely give my (our) informed consent for the use of nitrous oxide/oxygen during dental treatment at Root Canal Dentists. I (we) understand that no guarantees are made regarding any medical or mental results associated with use of this sedation technique.

_____ I (we) also understand that the cost for N_2O is **$40 per visit, excluding Medicaid/ Chip** patients, which will be collected **prior** to treatment because this inhalation sedation treatment is separate from my dental treatment and is not covered by my (our) insurance policy.

Patient Signature _____ Date _____

Patient Printed Name _____

_____Check if you are the parent or guardian of the named patient (if patient is under 18 y.o.)

Guardian's Signature _____ Contact #: _____

Printed Name _____Relationship _____

Doctor's Signature_____ Assistants' Signature_____

Form of Payment: MC, VS, AMEX, DISC, Check, Cash

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In our efforts to comply with the Health Information Privacy Act, HIPAA, we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Please circle your response to the following:

May we leave messages concerning your appointments / treatment with a co-worker, receptionist or secretary that your calls?	YES	NO	N/A regularly answers
May we leave messages on a voice mail at work'?	YES	NO	N/A
May we leave messages on an answering machine at home?	YES	NO	N/A
May we discuss your appointments *I* treatment with your spouse?	YES	NO	N/A
For any children above the age of 18, still living at home, may we discuss your appointments / treatment with your parent(s) or guardian?	YES	NO	N/A

You must inform us, in writing, of any changes in your directives. This record takes effect April 14, 2003 and will be kept in your file along with your acknowledgement of receipt of your Notice of Privacy Practices.

Signature:_____Date:_____

Witness:_____

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.

_____Please Print Name

Signature Date

_____

For **Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to Sign
- Communications bafflers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify) _____

_____

_____

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