SOUTHTOWN ENDODONTICS

american association of endodontists

Patient Registration & Information

Date _____

Patient Name _____ Date of Birth _____ Referring Dentist _____

Social Security Number _____ Cell _____ Alt. Phone _____

Address _____ City _____ State _____

Zip _____ Email _____ Employer _____

Minor's Responsible Party Information *(required if patient is under 18)*

Name of Responsible Party _____ Relation _____

Social Security Number _____ Date of Birth _____ Cell _____

Email _____ Address _____

City _____ State _____ Zip _____ Employer _____

Emergency Contacts - *please list at least one*

Contact Name _____ Relation _____ Cell _____

Contact Name _____ Relation _____ Cell _____

Primary Dental Insurance Information

Please provide card to front desk. If digital, please email to endotwins@gmail.com

Policy Holder Name _____ Relation (if different to self) _____

Insurance Co. _____ Address _____ City _____

State _____ Zip _____ Group Number _____ ID Number _____

If you are not the policy holder, please complete the section below with policy holder info.

Social Security Number _____ Date of Birth _____ Cell _____

Address _____ City _____

State _____ Zip _____ Employer _____

Secondary Dental Insurance Information

Please provide card to front desk. If digital, please email to endotwins@gmail.com

Policy Holder Name _____ Relation (if different to self) _____

Insurance Co. _____ Address _____ City _____

State _____ Zip _____ Group Number _____ ID Number _____

If you are not the policy holder, please complete the section below with policy holder info.

Social Security Number _____ Date of Birth _____ Cell _____

Address _____ City _____

State _____ Zip _____ Employer _____

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Health Questionnaire

Please check all that apply

Allergies

Latex _____ Penicillin _____ Local Anesthetics _____

Aspirin _____ Codeine _____ Sulphur Drugs _____

Other _____

Medications

Antibiotics _____ Antihistamines _____ Blood Pressure _____ Cortisone/Steriods _____

Anticoagulants _____ Aspirin _____ Chemotherapy _____ Tranquilizers _____

Other _____

Health Conditions

Cardiovascular System

High Blood Pressure _____
Low Blood Pressure _____
Heart Condition _____
Rheumatic Fever _____
Stroke _____
Other _____

Nervous System

Epilepsy _____
Nervous Breakdown _____
Drug Dependency _____
Other _____

Endocrine System

Diabetes _____
Thyroid Disease _____
Other _____

Skeletal System

Arthritis _____
Joint Replacement _____
Other _____

Respiratory System

Tuberculosis _____
Pneumonia _____
Asthma _____
Sinus Trouble _____
Nicotine Use _____ Smoke / Vape
Other _____

Infectious Diseases

Hepatitis _____
Venereal Disease _____
HIV Positive _____
Herpes _____
Other _____

Gastrointestinal System

Stomach Issues _____
Liver Disease _____
Ulcers _____
Other _____

Genitourinary System

Kidney Disease _____
Other _____

Blood System

Anemia _____
Abnormal Bleeding _____
Transfusions _____
Other _____

Head

Head or Jaw Injuries _____
Headaches _____
Dizzines _____
Other _____

Have you ever been informed of the need for premedication prior to dental treatment? ☐ Y / N ☐

I have read the above information and confirm everything is correct. Signature: _____

Informational Informed Consent

Root Canal Therapy

I understand that Root Canal Therapy includes possible inherent risks such as, but not limited to, the following: (I understand that no promises or guarantees of results have been made nor are implied).

1. The treated tooth may remain tender or even quite painful for a period of time, both during and after completion of therapy. If pain is severe or swelling occurs, it is imperative to call our office immediately. There is also a possibility of numbness occurring and/or persisting in the tongue, lips, teeth, jaws and/or facial tissues which may be a result of the anesthetic administration or from treatment procedures. This numbness is usually temporary, but, rarely could be permanent.

2. In some teeth, conventional root canal therapy may not be sufficient. If the canals are calcified, roots excessively curved or inaccessible, inadvertent pulp chamber or root perforation may occur. If there is infection in the bone surrounding the tooth healing may be prolonged and retreatment, extraction or a surgical apicoectomy may become necessary. In unusual cases, hospitalization or I.V. antibiotics may be necessary to treat an endodontic infection.

3. Root canal treated teeth must be protected. During and after treatment, your tooth in most instances will have only a temporary filling. Should this come out during or after treatment, you must contact our office immediately to arrange for replacement. Root canal treated teeth may become brittle and, due to the undermined or reduced tooth structure, may be subject to cracking or fracturing. Crowning or capping the treated tooth is the best precautionary measure to help avoid this from occurring; this procedure should be performed as soon as

4. Root canal therapy is not always successful. Many factors influence success; adequate gum tissue attachment and bone support; oral hygiene; previous and present dental care; general health; trauma; pre-existing undetected root fractures, accessory or lateral canals; etc. It may be difficult to place filling material to the end of the tooth (underfill) or some filling material may extrude from the tooth (overfill)m which can, in some cases cause inflammation, nerve damage resulting in residual infection. Even thoug ha tooth may have appeared to be successfully treated, there is always the possibility of failure making additional root surgery (apicoectomy) or extraction necessary. If a bridge abutment or crowned tooth requires endodontic therapy, the chance for perforation is enhanced due to obscured anatomy.

5. A crown abutment or crown (cap) may be damaged or destroyed during rubber dam application, access preparation, or other procedures as part of endodontic therapy. Porcelain is particularly sucseptible to fracture or cracking, and an existing porcelain crown may have to be remade, particularly if the pre-existing crown is all-porcelain in design.

6. Root fracture is one fo the primary reasons for root canal failure. Unfortunately, "hairline: cracks are almost always invisible and undetectable. Causes of root fracture are trauma, inadequately protected teeth, initial cracking of the coronal portion of the tooth, pre-existing large fillings, improper bite, excessive wear, habitual grinding of teeth, etc. Root fracture after or prior to treatment usually necessitates extraction.

7. There are alternatives to root canal treatment. These alternatives (though not of choice) include; no treatment; extraction; extraction followed by bridge or partial denture placement; an/or extraction followed by implan and crown placement.

8. Because of the fragility and small diameter of root canal instruments used in root canal treatment, there exists the possibility of instrument separation (breakage) which may or may not be detected at time of treatment. Although it is often possible to bypass or incorporate separated instruments within the filling material, instrument separation may result in the need for retreatment, surgical retrieval or extraction of the tooth.

9. Medications. Analgesics and/or antibiotics may need to be prescribed depending on symptoms and/or treatment findings. Prescription drugs must be taken according to instructions. Women on oral contraceptives must be aware that antibiotics cause contraceptives to become ineffective. Other methods of contraception must be utilized during the treatment period.

10. Irrigants. During root canal therapy, irrigants such as sodium hypochlorite are used to enhance tissue removal and swelling, bruising, inflammation and in rare cases, tissue necrosis.

11. Long appointments. There is the potential for long appointments to complete the procedures, and jaw muscles may be sore following the procedure. A pre-existing jaw problem (TMD) may be aggravated by endodontic re-treatment due to extended opening.

12. Once treatment has begun, it is absolutely necessary that the root canal treatment must be completed. One or more appointments may be required to complete treatment. It is the patient's responsibility to seek attention should any unanticipated or undue circumstances occur. Also, the patient must diligently follow any and all preoprative and/or posoperative instructions given by the dentist and/or the staff.

Informed Consent

I have been given the opportunity to ask any questions regarding the nature and purpose of root canal treatment and have received answers to my satisfaction. I understanstand that Dr. VanDenBerghe of Southtown Endodontics is a specialist in endodontics. I do voluntarily assume any and all possible risks including, but not limited to, those listed above, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired potential results, which may or may not be achieved. No promises or guarantees have been made to me concerning the results. The fee(s) for this service have been explained to me and are satisfactory. By signing this document, I am freely giving my consent to allow and authorize Dr. VanDenBerghe, and/or his/her associates or agents to render any treamtnet necessary and/or advisable to my dental conditions(s), including prescribing and administering any and all anesthetics and/or medications.

_____

Signature of patient, legal guardian, or authorized representative

_____

Patient's Name (print)

_____

Date

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Financial Policy

1. You are fully responsible for your account.

2. A portion of the total fee is due at the time of treatment, regardless of insurance coverage.

3. *Dental Insurance*

We are happy to file the forms necessary to see that you receive the full benefits of your coverage; however, we cannot guarantee any estimated coverage. Because your insurance policy is an agreement between you and the insurance company, we require that all patients be directly responsible for all charges. Due to the large number of insurance companies that our office encounters, it is your responsibility to know the details, benefits and limitations of your insurance policy. We will do everything possible to see that you receive the full benefits of your policy. If for some reason your insurance company has not paid their portion within 60 days from the date of treatment, you are responsible to pay their portion. You are responsible to pay any balance remaining after your insurance pays their portion. (All accounts are to be paid in full within 90 days.)

4. *No Insurance*

We require a minimum of $250 at the time of treatment. The balance may be set up between 3-6 payments and must be deducted from either debit card or credit card. Cash will not be accepted for future payment plan payments.

5. If you are financed by this office, payment will be deducted **monthly.**

6. Accounts that receive no payments for 90 days will be placed with an attorney for collection and listed with a credit bureau. In the event of default, the undersigned agrees to pay collections fees of an additional 40% of balance owed and legal fees of collections (with or without suit, including court costs and attorney fees.)

7. *Preffered Payment Options:*

Cash or Check: Checks will be electronically debited from your account. You understand and authorize checks, if dishonored, plus a processing fee with applicable taxes to be electronically debited from your account.

Credit Card: We accept payment by Visa, MasterCard, American Express and Discover.

With my signature, I certify I have read and understand the above financial policy, agree to it and will abide by it.

_____ _____

Signature **Date**