Welcome to Westshore Endodontics!

We sincerely appreciate the opportunity to be a partner in your dental care! Our goal is to provide our patients with quality, caring service. In order for us to begin, we need your participation in completing some necessary information on these following forms. If you have any questions at any time, please feel free to ask one of our staff members.

Patient Information

FULL NAME ____
Last First (& Nickname, if applicable) MI

ADDRESS ____
Number & Street City State Zip Code

HOME PHONE #______________________ CELL PHONE #______________________

EMAIL ADDRESS ________________________________ Okay to send email? □ Yes □ No

BIRTHDATE ________________________ SOCIAL SECURITY # ______________________

PLACE OF EMPLOYMENT ____________________________ WORK PHONE #__________________

MARITAL STATUS: □ Married □ Single

SPOUSE'S INFORMATION OR PARENT/GUARDIAN INFORMATION (if the patient is a minor)

FULL NAME ____
Last First MI

ADDRESS *(only if different from patient's address)*

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Number & Street City State Zip Code

HOME PHONE #______________________ CELL PHONE #______________________

BIRTHDATE ________________________ SOCIAL SECURITY # ______________________

PLACE OF EMPLOYMENT ____________________________ WORK PHONE #__________________

HIPPA

I hereby authorize the following persons to receive my personal health information (electronic or verbal), including information regarding appointments, treatment, insurance, and financial obligations.

Name and Relationship ______________________________________ Phone #__________________

Name and Relationship ______________________________________ Phone #__________________

Name and Relationship ______________________________________ Phone #__________________

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Signature of Patient (Parent or Guardian if Minor) **Date**

HEALTH INFORMATION

Dentist's Name: ______________________________ Medical Physician's Name: _________________________________
Have you ever had a root canal before? □ Yes □ No
Is your current dental problem accident related? □ Yes □ No Accident Type & Date: ___________________________
Are you required to be pre-medicated with antibiotics prior to dental work? □ Yes □ No

Medications and Allergies

Current prescription(s) or over the counter medications you are taking: (If you have a list, we can photocopy it)

Antibiotics □ ____
Pain Medication □ ____
Heart Medication □ ____
Aspirin □ ____
Blood Pressure Meds. □ ____
Blood Thinners □ ____
Cortisone/Steroid □ ____
Diabetes Meds. /Insulin □ ____
Thyroid Medication □ ____
Hormones □ ____
Other (please list ALL other medications)
____
____

Please check any you are allergic to:

□ Acetaminophen (Tylenol, etc.)
□ Latex
□ Penicillin / Amoxicillin
□ Aspirin
□ Local Anesthetic
□ Codeine
□ Metals
□ Erythromycin/Azithromycin
□ Nitrous Oxide
□ NSAIDS (Advil, Ibuprofen)
□ Sulfa
□ Other antibiotics
□ Additional Allergies (please list)
____

Current or Previous Conditions

Do you have/or had any of the following:

□ Heart Defect / Murmur / Afib
□ Heart Surgery / Pacemaker / Valve Replacement
□ Heart Attack / Failure / Disease
□ High/Low Blood Pressure (circle one)
□ Blood Transfusion
□ Hemophilia / Abnormal Bleeding
□ HIV / AIDS
□ Hepatitis, type: ________
□ Tuberculosis (TB)
□ Asthma / Difficulty Breathing / Emphysema / COPD
□ Lung Disease
□ Sinus Trouble / Seasonal Allergies
□ Arthritis
□ Osteoporosis
□ Joint Replacement
□ Kidney Disease / Frequent Urination
□ Dialysis

□ Stroke / TIA(s)
□ Fainting/dizzy spells/epilepsy/seizures
□ Diabetes □ type I □ type II
□ High/Low Blood Sugar (circle one)
□ Thyroid Disease
□ Anxiety / Depression / Panic Attacks
□ Mental Health Treatment
□ Substance Abuse Addiction
□ Liver Disease
□ Ulcers / Crohn's Disease / Colitis
□ Cancer / Chemotherapy / Radiation Type_______ Date____
□ Tumor
□ Organ Transplant / Removal
□ Are you currently pregnant? If yes, # of months ______
□ Pain in jaw joints / TMJ
□ Recent Tooth Pain Scale 1-10 _______

Additional Information

♦ List any major surgeries or health events that have occurred.

♦ Are you under a physician's care for a current health concern at this time? If yes, please explain;

♦ Additional comments concerning your health we should be aware of?

I certify that the above information, to the best of my knowledge, is accurate and correct.

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Signature of Patient (Parent or Guardian if Minor) **Date**

INFORMED CONSENT

Notice of Privacy Practices

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me *(available at the check in counter)* and I have been given the opportunity to ask any questions I may have regarding this Notice. My signature signifies that I am giving my consent to Westshore Endodontics use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. I am aware that I have the right to refuse this acknowledgment.

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Signature of Patient (Parent or Guardian if Minor) Date

Informed Consent

Endodontic Therapy or Root Canal is performed in order to save a natural tooth that might otherwise require extraction. Endodontics, as with any branch of medicine, is not an exact science and no guarantee of treatment success can be given or implied and occasionally a tooth which has had root canal therapy may require retreatment, surgery or extraction. Cases started in other offices or previously started and not completed, as well as retreatment cases, are usually more difficult and may have a different outcome than expected under optimal conditions.

As with any dental treatment, there can be complications resulting from the use of instruments, drugs, analgesics (pain killers) and injections. The most common dental complications include (but are not limited to): swelling, soreness or pain, infection, sensitivity, bleeding of the teeth, gums and mouth, jaw muscle cramps or spasms, temporomandibular joint (jaw) difficulty, reactions to injections or complications following anesthesia (paresthesia, hematoma, allergies, increased heart rate), and discoloration of the adjacent soft and hard tissues. Much less common is a numbness or tingling sensation of the lips, chin, gums, face, tongue, or related tissues. This is normally transient but, on very rare occasions, may be permanent.

Additionally, endodontic treatment involves the use of specialized instruments in confined spaces. Even with very careful use of these instruments, complications may occasionally occur. These may include (but are not limited to): broken instruments within the tooth, perforation of the crown or root of the tooth during treatment, damage to existing dental work or appliances, some loss of tooth structure while gaining access to the canals, fractures of the crown or root of the tooth, and other unknown or unanticipated problems, for which the explanation of responsibility cannot be given or assumed. During treatment, complications may be discovered which make treatment impossible or may require a surgical procedure. Difficulties may include: blocked canals due to fillings or prior treatment, natural calcifications, curved roots, periodontal disease, fragments of instruments within the canal, or a fracture of the tooth.

Some medications and drugs may be prescribed or used during treatment and can cause drowsiness or lack of awareness and coordination. Side effects might also include (but are not limited to): nausea, vomiting or allergic reactions. These drugs and medications may be influenced by the use of alcohol, tranquilizers, sedatives and other drugs. If prescribed, it is not advisable to operate any vehicles or hazardous machinery/devices until you have fully recovered from the effects.

UPON COMPLETION OF YOUR ROOT CANAL THERAPY, YOU MUST RETURN TO YOUR GENERAL DENTIST FOR A PERMANENT RESTORATION OF THE TOOTH. PERMANENT RESTORATION IS ABSOLUTELY NECESSARY AS A FINAL STEP IN SAVING YOUR TOOTH. FAILURE TO HAVE PERMANT RESTORATION WITHIN 30 DAYS WILL RESULT IN THE PATIENT'S RESPONSIBILITY FINANCAILLY FOR ANY FURTHER TREATMENT.

Alternatively, upon examination the patients may opt for no treatment at this time and wait for more definitive symptoms to develop. The risks of no treatment could include (but are not limited to): pain, swelling, infection, increased bone loss, or loss of the tooth. Patients may also opt for extraction of the tooth.

My signature below signifies that I have read and understand the above informed consent. Additionally, I authorize my endodontist and their designated staff to perform an oral and maxillofacial examination for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays, scans, and testing required as a necessary part of the examination.

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Signature of Patient (Parent or Guardian if Minor) Date

PLEASE <u>DO NOT</u> SIGN BELOW UNTIL YOU HAVE DISCUSSED YOUR TREATMENT WITH THE DOCTOR.

I have had the opportunity to discuss and ask questions concerning the nature, inherent risks and alternatives of my proposed treatment and I am satisfied with the discussion. I hereby give consent to the recommended treatment.

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Signature of Patient (Parent or Guardian if Minor) Date

(For Staff Use Only) – TOOTH NUMBER & TREATMENT TO BE DONE:

FEE SCHEDULE

Our usual and customary fee schedule, listed below, is accepted by most insurance companies in the State of Michigan.

Root Canal		Root Canal Retreatment		Other	
Anterior Teeth	$1,065	Anterior Retreatment	$1,375	Nitrous Oxide	$40
Premolar Teeth	$1,170	Premolar Retreatment	$1,495	CBCT and Interpretation	$200
Molar Teeth	$1,300	Molar Retreatment	$1,650	Core Build Up	$100

Please note:

We accept checks, cash, major credit cards (visa, mastercard, discover, american express) and Care Credit as payment for services. There will be a $30.00 charge for any returned checks.

In the event of an appointment canceled within 24 hours or a no show, we will require a credit card number to reschedule. No charge will be accessed unless there is a second cancelation or no show in which a $100 fee will be charged to the card on file.

PATIENTS WITH NO DENTAL INSURANCE

We respectfully request that you complete payment in full at the time of treatment. Thank you.

DENTAL INSURANCE INFORMATION ONLY (Please complete fully)

Westshore Endodontics provides predeterminations and estimates based on what information your insurance company has provided us with. We request that the estimated portion of your treatment (not covered by your insurance) be paid in full at the time of your treatment. **You will be responsible to pay any deductible amount, co-insurance or any other balance not paid by your insurance company. If payment for services rendered has not been received from you, within 30 days of your first statement the remaining balance is subject to collections.** We are happy to submit insurance claims as a courtesy to our patients and assist you wherever we can.

PRIMARY DENTAL INSURANCE COMPANY____

EMPLOYER NAME ____________________________________ GROUP #_______________

ID or SOCIAL SECURITY # OF PRIMARY SUBSCRIBER_________________________________

SUBSCRIBER'S NAME and BIRTHDATE ____________________________________

If Applicable:

SECONDARY DENTAL INSURANCE COMPANY____

EMPLOYER NAME____________________________________GROUP #_________________

ID or SOCIAL SECURITY # OF SECONDARY SUBSCRIBER ______________________________

SUBSCRIBER'S NAME and BIRTHDATE ____

PLEASE SIGN.

I have read and understand the above financial information & agree to the payment conditions above. I also authorize all insurance payments & other third party payments to be made directly to Westshore Endodontics & Taryn K. Harreld, D.D.S., M.S. and Janine Matos, D.D.S., M.S. for all dental expenses incurred.

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Signature of Patient (Parent or Guardian if Minor) **Date**