ROOT CANAL SPECIALISTS

Patient Information

Last Name: _____ First Name: _____ MI: ___
Address: _____
City: _____ State: _____ Zip: _____

Birth Date: ____/____/____ Age: ____ Social Security # _____
Marital Status: Single_____ Married _____ Divorced _____ Widowed _____
Sex: Male ___ Female ___

E-mail: _____

Phone#: Home (___) ____-_____ Work (___) ____-_____ Cell (___) ____-_____
Employed by: _____ Position: _____

Spouse's Last Name: _____ First Name: _____ MI: ____
Telephone Home (___) ___-____ Work (___) ___-____ Cell (___) ___-_____
Birth Date: ____/____/____ Age: ____ Social Security # _____
Employed by: _____ Position: _____

Responsible Party (if under 18)

Last Name: _____ First Name: _____ MI: ____
Relationship to patient: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: Home (___) ___-_____ Work (___) ___-_____ Cell (___) ___-_____
Birth Date: _____/____/____ Age: ____ Social Security # _____
Employed by: _____ Position: _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____
Birth Date: ____/____/____ Social Security # _____ Date Employed_____
Name of Employer: _____ Union or Local # _____ Work #_____
Address of Employer: _____
City: _____ State: ____ Zip _____
Insurance Company: _____ Group # _____ Policy/ID# _____
Ins. Co. Address: _____ City _____ State _____ Zip _____
How much is your deductible? _____How much have you used? _____
Annual Max Benefits_____

DENTAL HISTORY

To assist us in promptly identifying your dental problem please answer the following questions.

Why did you come to see the dentist today? _____

Present Discomfort:

Are you experiencing any discomfort right now? _____ NO YES
Can you point to the tooth causing the discomfort? _____ NO YES
Have you taken any medications or tried anything to relieve the pain? _____ NO YES
If yes, Please list any medications _____
Today, is the tooth painful / sore to one or more of the following? **Hot Cold Sweets Biting None**

Past discomfort:

Have you ever had a gum boil or swelling on the gum around that tooth? _____ NO YES
In the past, was the tooth sensitive to one of the following? **Hot Cold Sweets Biting None**
When did you first notice any problems with the tooth? _____
When is / was the discomfort most noticeable (incident time)? _____
Describe the pain you experienced? **Dull Throbbing Aching Sharp jabbing Hurts by itself**
Hurts only if I stimulate it Severe Moderate Mild
Were you ever treated for this problem? _____ NO YES
If yes, did the treatment relieve the pain? _____ NO YES
Do you consider your other teeth sensitive? _____ NO YES

MEDICAL HISTORY

Check the following you had had in the past or have at the present:

__Heart problems: Surgery, Pacemaker, Irregular Beat, heart Attack, Murmur, Angina, Mitral Valve Prolapse, Rheumatic Fever, Chest Pain, Artificial Heart Valve, Other_____
__Diabetes
__Seizures / Epilepsy
__Hemophilia / Bleeding Problems
__Cancer / Radiation Therapy
__Thyroid Disease
__Nervousness
__Alcoholism
__Weight Loss

__Lung Problems: TB, Emphysema, Asthma
__Liver Problems: Cirrhosis, Hepatitis
__Artificial Joints: Hips, Knees, Etc.
__High Blood Pressure
__Lupus
__Stroke
__Kidney Problems
__HIV / AIDS
__Ulcers
__Pregnant / Nursing
__Night Sweats
__Productive Cough
__Venereal Disease
__Latex Allergy

Do you have any disease or condition not listed? NO YES Describe in detail _____
Are you currently taking or have you taken Bisphosphonate medications within the past 12 year? NO YES
Are you or have you been:
(1) Under a doctor's care? NO YES WHY? _____
(2)Hospitalized in the past 2 years? NO YES WHY? _____
List any drug allergies:
__Penicillin __Codeine __Aspirin __Anesthetics like Novacaine __Other _____
_____
_____
List all medications you're taking, including birth control pills: _____
_____
_____

I understand I am to report any changes in my medical condition or medications.
Patient's / Guardian's Signature _____ Date _____
Doctor's Signature _____ Date _____

Root Canal Specialists

Print First and Last Name:_____

Dental History:

1. Have you had a crown placed in the last 3 months? _____
2. If **Yes**, please write down on which sides of your mouth and approximate date_____

_____

_____

3. Do you currently have a temporary crown in your mouth? **YES / NO**. If YES approximate date

_____

_____

_____

4. Are you scheduled to return to your General Dentist? **Yes / NO** When? _____
5. Have you seen any Dental Specialists in the past 3 months? _____

_____

_____

Patient's Signature: _____

Date: _____

Root Canal Specialists
1314 E. Sonterra Blvd. Suite 301
San Antonio, TX. 78258
210-495-6710

Consent Form for Non-Surgical Canal Therapy

A root canal is the removal of the nerve tissue (pulp) from the roots of the tooth and its replacement with filling materials. Although root canals are highly successful, some root canals may need to be redone or followed up by surgery. Re-treating a root canal involves removal of old root canal filling material and replacing it with a new one. X-rays and discomfort either soon after the root canal or years later will indicate whether you will need these procedures. In other words, there is no guarantee that a root canal will be successful. You will need to decide for yourself whether you prefer pulling the tooth or try to keep it for as long as possible with a root canal.

1. **Grinding through crowns will alter the shape and look of the crown, especially if porcelain. If the crown comes off or breaks, you will need to have it replaced by your dentist at your own cost.**
2. **In the attempt to get down curved root canals or closed-up (calcified) root canals, instruments used during root canal procedures may break off inside the root canal. In most cases, the broken instrument cannot be removed and will be incorporated in the filling material. If this happens, you might not have the option for re-treatment in the future on that root.**
3. **In an attempt to enter and clean closed up (calcified) roots, an opening to the outside of the root (perforation) may inadvertently occur.**
4. **Even with today's scientific advances, small branches of the main root canal cannot be cleaned out and filled.**
5. **With a new root canal or a retreatment, preexisting calcification and blockage can only be learned about after we are inside the tooth; this may affect the tooth's long-term prognosis.**
6. **Cracks that extend down the root surfaces cannot be easily detected, even with a microscope. Unfortunately, teeth with this type of crack may have to be pulled even after you have gone through a root canal treatment.**
7. **If you were told that you have a dark spot in your jaw bone at the tip of the root, you should return to our office within 6 months of your root canal, to make sure that dark spot is going away. You may feel perfectly fine, but the dark spot could be growing and eventually cause additional complications. So please follow up for your health benefit.**
8. **If you have a history of TMJ or jaw pain and discomfort; having your mouth open during treatment may temporarily increase your symptoms. Let us know if you get tired, we can always do the treatment in sessions.**
   Typically, root canals treatment will only address the tooth's pain, and not any TMJ pain.
9. **You will probably leave our office with a temporary filling; if so, please make you see your primary dentist for a permanent filling or crown soon after your root canal.**
   Your discomfort after the root canal may last days two weeks. Everyone reacts differently. Motrin and Advil (ibuprofen) work best to alleviate the discomfort (if these medications agree with your medical history).
   Please let us know if you need a stronger pain medication to help you during this period.
   Feel free to contact your doctor at the after-hours number, if necessary.
10. **Adverse medical effects from local anesthetic injections are possible, which includes but are not limited to temporary numbness of the lip or tongue.**
11. **Your healing ability and medical history may affect and slow down the healing process.**

Please let us know if there's something that you don't understand so we may explain it more in depth. We will let you know how everything went at the end of your treatment.

PRINT NAME: _____

SIGNATURE: _____ DATE: ____/____/_____

ROOT CANAL SPECIALISTS
SAN ANTONIO, TEXAS

HIPPA – NOTICE OF PRIVACY PRACTICES

Your personal information will be used and disclosed to pay for your dental bill. Your personal information will be used to obtain payment for services we provide to you.

Your dental information will be forwarded to your family dentist via written mailed report or via email to them. We can also forward them to any dentist you request us at a later date.

You will get correspondence via U.S. mail at times from our office for recall, billing or any other matter in regards to your account/care.

We will call and leave a message in your voice mail or answering machine for appointment reminders, post-op courtesy or ask you to call us back.

If you would like a family member or caretaker to have access to your dental records or billing record, please write their name down on this paper and your relationship to this person.

Name: _____ Relationship: _____

We ask for your credit card information if we are estimating the insurance co-payment. You should NOT disclose the 3-digit security code. Without the security code, your credit card information can't be used in other facility other than our office and that will be used in collection of any outstanding balance that you don't pay.

Print Patient's Name: _____

Signature: _____ Date: _____

Our Office Financial Policy

Welcome to our Office.
We believe an informed patient is a happy patient.

1. **Patients who do not have insurance coverage:**
~ 100% of payment is due at the time of visit in cash/credit/debit or care credit card that bears your name on it. Please make sure that you get a receipt for your payment.
~ We use your social security number in collection of your account. If you are paying 100% by with cash or credit card, you can disclose the last 4 digits of your social security number. Only which identifies your record from another identical name.
~There may be additional fees other than quoted initially if there are calcifications, perforations, root curvature or any other issues that make the treatment more difficult. Unfortunately, some of these fees are noted when the dentist is in the process of doing the root canal.
~Not showing up with a previously confirmed appointment or canceling without a 24-hour notice will cost you $50.00 as we have to reserve that time for you.

2. **Patients who have insurance coverage:**
~As a courtesy to you, we are collecting an ESTIMATED co-payment based on a verbal confirmation with your dental insurance company. If the insurance company doesn't honor what they have disclosed over the phone, you are responsible for paying it. If you disagree with a payment by your insurance, you will have the responsibility of calling them and resolving the problem.
~All examinations will be collected at 100% today and insurance will be submitted on your behalf. If your insurance pays, it can be credited back towards your root canal or you can call for a refund back on your credit card or we can send you a check that is automatically voided if not cashed in a timely manner.
~You will incur an administrative charge if we have to research a refund check that may be lost.
~Your full social security number and your driver's license is needed in regards to collections of your account. If you choose not to disclose this information, you can pay 100% of the fees and submit the claim yourself.
~There may be additional fees other than quoted initially if there are calcifications, perforations, root curvature or any other issues that make the treatment more difficult. Unfortunately some of these fees are noted when the dentist is in the process of doing the root canal.
~Not showing for a previously confirmed appointment or canceling without 24-hour notice will cost you $50.00 as we have reserved that time for you.

Signature_____ Date_____