RootVision Endo

Please print (blue or black ink only)

Patient: _____
Last Name First Name Middle Initial Preferred Name

Home/Cell Phone #: _____ Social Security #: _____

Mailing Address: _____
Street City State Zip Code

Sex: M / F Age: _____ Birthdate: _____/_____/_____ Status: Single / Married / Widowed / Separated / Divorced

Employed By (if minor, list school): _____ Occupation: _____

E-mail Address: _____ Business Ph#: _____

Insured's Name: _____ SS#: _____ Birthdate: _____/_____/_____

Insured Employed By: _____ Occupation: _____ Work Ph#: _____

Primary Dental Insurance Co.: _____ Group#: _____

Secondary Insured's Name: _____ SS#: _____ Birthdate: _____/_____/_____

Secondary Dental Insurance Co.: _____ Employer: _____ Group#: _____

Emergency Contact: _____ Phone Number: _____

Whom may we thank for referring you: _____ Dentist Name: _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____ and assign to RootVision Endo
Name of Insurance Company/Companies

all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure the payment for benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Date Signature

MINOR CHILD CONSENT

I, being the parent or guardian of _____ do hereby request and authorize the dental
Name of Minor/Child

staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

_____ _____
Date Signature

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of consultation/treatment unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for consultation/treatment of a minor/child. **I accept full financial responsibility for all charges not covered by insurance. I am aware that I am responsible for any cost(s) incurred in collection of a delinquent account.**

_____ _____
Date Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below you are acknowledging receipt and understand all written information regarding our offices' privacy practices.

_____ _____
Date Signature

HEALTH HISTORY

Patient _____ Patient #: _____ Date: _____

Last Name First Name Middle

Please answer each question by checking the appropriate box or circling YES or NO:

1. Are you in good health?..... Yes No
2. Date of last physical examination: _____
3. Are you now under the care of a physician? ……..... Yes No
   If yes, what is the condition being treated? _____
   Doctor's name: _____ Telephone #: _____
4. Have you ever has any serious illness or operation or been hospitalized? …….. Yes No
5. Are you taking any medication? …….. Yes No
   If yes, what? _____ What dosage? _____
6. Are you using any recreational drugs (e.g. marijuana, cocaine) or controlled substances? …….. Yes No
   If yes, what? _____
7. Have you ever been pre-medicated with antibiotics for your dental treatment? …… Yes No
8. Are you sensitive or allergic to any drugs or materials? __ Penicillin __ Tetracycline __ Erythromycin
   __Aspirin __ Codeine __ Latex __Other If Other, please list: _____ Yes No
9. Do you have or have you had any of the following: Please check "Y" for Yes or "N" for No **– *answer all conditions:***

Y / N	Aids	Y / N	Cortisone Medicine	Y / N	Hemophilia	Y / N	Respiratory Disease
Y / N	Allergies or Hives	Y / N	Diabetes	Y / N	Hepatitis of Jaundice	Y / N	Rheumatic Fever
Y / N	Allergies to Metals	Y / N	Difficulty in swallowing	Y / N	Herpes	Y / N	Rheumatism
Y / N	Anemia	Y / N	Drug Addiction	Y / N	High Blood Pressure	Y / N	Sickle Cell Disease
Y / N	Angina Pector	Y / N	Emphysema	Y / N	HIV Positive	Y / N	Sinus Trouble
Y / N	Arthritis	Y / N	Epilepsy or Seizures	Y / N	Joint Replacement	Y / N	Stomach Ulcers
Y / N	Artificial Heart Value	Y / N	Excessive Bleeding	Y / N	Kidney Disease	Y / N	Stroke
Y / N	Asthma	Y / N	Fainting Spills/ Seizures	Y / N	Liver Disease	Y / N	TMJ
Y / N	Blood Disease	Y / N	Glaucoma	Y / N	Mental Disorder	Y / N	Thyroid Disease
Y / N	Blood Transfusion	Y / N	Hay Fever	Y / N	Mitral Valve Prolapse	Y / N	Tonsillitis
Y / N	Bruise Easily	Y / N	Head Injuries	Y / N	Nervous Disorders	Y / N	Tuberculosis
Y / N	Chemotherapy	Y / N	Heart Ailments or Attack	Y / N	Pain in Jaw Joints	Y / N	Tumors or Growths
Y / N	Cold Sores	Y / N	Heart Failure	Y / N	Psychiatric Treatment	Y / N	Venereal Disease
Y / N	Congenital Heart Lesions	Y / N	Heart Murmur	Y / N	Radiation Treatment		

10. Do you wear a cardiac pacemaker, or have you had heart surgery? If yes, please explain: _____ Yes No
11. Do you smoke, chew, use snuff or any other forms of tobacco? __ Cigarettes __Cigars __ Chew __ Snuff __Other Yes No
    If yes, how much? _____
12. Do you consume alcoholic beverages? If yes, how much? _____ …….. Yes No
13. Have you ever taken the drug "Fen-Phen" or "Redux"? …….. Yes No
14. Are you pregnant? If yes, how many months? _____ …… N/A Yes No
15. Do you have any problems associated with your menstrual period? …… N/A Yes No
16. Do you take birth control pills? …… N/A Yes No
17. Is there anything we should know about your health that is not mentioned above? ……. Yes No
18. Are you or have you been taking Bisphosphonate (Fosamax) in the last three months? …….. Yes No

1st **I CERTIFY THAT THE ABOVE INFORMATION IS COMPLE AND ACCURATE**

Date: _____ Signature: _____

(If patient is a minor, include printed name and signature of parent or legal guardian)

2nd ***UPDATE- Since your last visit:***

1. Have you seen a medical doctor? …….. Yes No
2. Have you had a change in any medication? ….. Yes No
3. Have you had a change in any medical condition or had surgery? …….. Yes No

If yes, please explain: _____

Date: _____ Signature: _____

3rd ***UPDATE- Since your last visit:***

1. Have you seen a medical doctor? …….. Yes No
2. Have you had a change in any medication? … Yes No
3. Have you had a change in any medical condition or had surgery? …….. Yes No

If yes, please explain: _____

Date: _____ Signature: _____

DO NOT WRITE IN THIS SPACE

	DATE	B.P.	PULSE	REVIEWED BY	DENTIST'S COMMENTS
1ST	_____	___/___	_____	_____	_____
2ND	_____	___/___	_____	_____	_____
3RD	_____	___/___	_____	_____	_____

PATIENT INFORMATION AND CONSENT FORM

I understand I will be seeing an Associate Endodontist of F. Mike Bardi, D.D.S., APC. My doctor is an independent contractor and is not an employee of F. Mike Bardi, D.D.S., APC. I allow the associate endodontist to evaluate my tooth/teeth for endodontic treatment.

Patient/Parent Signature	Print Name	Date

TOOTH IN QUESTION: #_____ / #_____ / #_____ / #_____ / #_____ / #_____ **(OFFICE USE ONLY)**

We believe that a patient must be well informed about any treatment and their consent must be given before starting the treatment. The purpose of this form is to inform you of the risks and complications that can occur, however infrequent, during a root canal treatment.

Endodontic treatment (root canal) is performed in an attempt to save a tooth which otherwise might require extraction. Although Endodontic treatment has a high degree of success, no guarantee can be given. Root canal treatment generally takes one to two visits and requires the use of local anesthetic and x-rays.

PLEASE INITIAL

____ I understand that the alternatives to endodontic treatment include: no treatment, waiting for more definitive development of symptoms, and extraction of the tooth. Risks involved in these choices may include pain, swelling, infection, loss of tooth or teeth, and infection to other areas.

____ I understand that in some cases, the tooth may require re-treatment of previous root canal therapy. Some complications may be encountered during this procedure due to previous treatment such as blockage, perforation, or broken instrument that may require endodontic surgery or even extraction in order to resolve.

____ I understand that the crown of the tooth may be cracked. Some cracks that extend from the crown down into the roots are invisible and undetectable. If a fracture occurs before or after the root canal treatment, the tooth may require extraction.

____ I understand that Endodontic surgery may be suggested as the best option. Surgeries that might be performed include: dividing a tooth in half, repairing an injured root, or even removing one or more roots. Intentional re-plantation may be performed where the tooth will be extracted, treated, and then replaced in the socket.

____ I understand that there may be complications resulting from the use of dental instruments, drugs, medicines, analgesics, anesthetics, and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensation on the lips, tongue, chin, gums, cheek and teeth, discoloration of tooth, discoloration of the face, antibiotic that may inhibit the effectiveness of birth control pills, thrombophlebitis (inflammation of the vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty , loosening of the teeth or restorations in the teeth, injury in other tissues, referred pain to the ear, neck and head, nausea, vomiting, allergic reactions, itching, bruises, delayed healing, sinus complications and further surgery.

____ I understand that specific risks to endodontic therapy can include instruments broken within the root canal(s), perforations (extra opening) 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 fracture of tooth structure. If existing restoration is either damaged or destabilized, a new restoration may be indicated.

____ I understand that during treatment, complications may be discovered which makes the treatment impossible, or may require Endodontic surgery. These complications may included: blocked or obstructed canals resulting from fillings, prior treatment, natural calcification, broken instruments, curved roots, perforations, periodontal disease (gum disease-Pyorrhea) and fractures of the teeth.

____ **I understand that after the completion of the Root Canal treatment, I will need to return to my regular dentist for the permanent restoration.**

____ I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted on roots canals, re-treatments, and surgical procedures.

During the course of the treatment, every effort will be made to achieve successful results and to keep you as comfortable as possible.

Doctors Initials _____

Patient/ Parent Signature	Date

BROKEN APPOINTMENT FEE POLICY

Appointment for specialty care is in demand. We require a **24-hour** notice in **advance** if you are unable to keep your scheduled appointment. If you fail to provide a 24-hour cancelation notice, you will be charged for the missed appointment. Those fees may vary from $100 to $200 per appointment.

Patient/Parent Signature	Date