Brian Whitten, D.D.S.
PRACTICE LIMITED TO ENDODONTICS

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Please Print Clearly

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

Name	
Spouse / Partner	
Address	
City, State, Zip	
Home Phone	Work Phone
Social Security #	Birthdate
Employer	
If patient is a minor, parent or guardian	
In case of emergency call	Phone(s)
Your regular (general) dentist	Phone
Your physician	Phone
How do you prefer to be addressed? (What should we call you?)	

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

☐ Self ☐ Spouse/Partner ☐ Parent ☐ Other ______

Insurance Company	
Group Code	
*(Complete if **not** yourself)*	
Employer	
Employee	
Social Security #	Birthdate

SECONDARY DENTAL INSURANCE *(if applicable)*

Insurance Company	
Group Code	
Employer	
Employee	
Social Security #	Birthdate

☐ Spouse/Partner ☐ Parent ☐ Other ______

MEDICAL HISTORY *(Confidential)*

	YES	NO
Are you in good health?	☐	☐
Are you currently under the care of a physician? For what condition? ______	☐	☐
Have you ever experienced any unusual complications following dental treatment?	☐	☐
Have you ever had excessive bleeding requiring special treatment?	☐	☐
Do you have significant anxieties about dental treatment?	☐	☐
Women		
Are you or might you be pregnant? Months? ______	☐	☐
Are you nursing an infant?	☐	☐
Are you taking oral contraceptives (birth control pills)?	☐	☐
Have you ever had any allergic or other adverse reaction to any medication or other substances?	☐	☐

If yes, please list ______

Please list any and all medications (including over the counter drugs) you are now taking ______

Please indicate any of the following you have had:

☐ Heart condition	☐ Sinus problems	☐ Glaucoma
☐ High blood pressure	☐ Hay fever / allergy	☐ Epilepsy / seizures
☐ Angina	☐ Ulcers	☐ Neurologic condition
☐ Rheumatic fever	☐ Colitis	☐ Fibromyalgia
☐ Mitral valve prolapse	☐ Liver condition	☐ Headaches
☐ Artificial heart valves	☐ Hepatitis A / B / C	☐ HIV / ARC / AIDS
☐ Pacemaker	☐ Blood condition	☐ Kidney condition
☐ Cochlear Implant	☐ Diabetes	☐ Arthritis / rheumatism
☐ Stroke	☐ Endocrine disorder	☐ Cortisone medications
☐ Respiratory condition	☐ Thyroid condition	☐ TMJ disorder
☐ Asthma	☐ Cancer	☐ Artificial joints
☐ Tuberculosis	☐ Radiation therapy	☐ Substance recovery
		☐ None of the above

Have you had any other serious illness not listed? ______

UPDATE MEDICAL HISTORY

Changes ______
Date ______ Initials ______
Changes ______
Date ______ Initials ______
Changes ______
Date ______ Initials ______

FINANCIAL INFORMATION

- **Payment is required at the time of service.** _______________ (Initial)
- If you have dental insurance, we will be happy to bill your insurance company as a convenience to you. You will be required to pay only your estimated co-payment at time of treatment.
- We offer a 5% discount for all fees paid in full at the initiation of treatment.
- We accept cash, checks, debit cards, Visa, MasterCard, and American Express.
- We do not offer any type of financing or payment plans.
- Uncollected funds owed over 90 days will be sent to a collection agency.

INSURANCE INFORMATION

- Please understand that regardless of insurance coverage you are responsible for all fees incurred. Your insurance policy is a contract between you and your insurance company. We will be happy to assist you in all claims, but we cannot guarantee your coverage.
- We will do everything we can to accurately estimate your co-payment, but differences may occur.
- Many insurance companies pay claims based on their own "UCR" fee schedules which are arbitrarily low and do not represent actual specialty fees in our area. Thus, they may not cover as high a percentage of the actual fees.
- If there is any question about your coverage, we will try to over estimate your portion so we will not have to bother you with a bill later. Any overpayment will be promptly refunded.
- Insurance patients may also take advantage of our 5% discount by paying in full, and we will request your insurance company send payment directly to you.
- Please ask us about anything concerning your treatment or the fees involved. We are here to help you!

CONSENT AND INFORMATION FORM

Regarding Health History, Endodontic (Root Canal) Therapy, Premedication, Local Anesthetic and Medication

It is the belief of this office that you should be informed about the treatment and that you should give your consent before starting that treatment.

Root canal treatment is done in order to save a tooth which would otherwise need to be removed. In general terms, root canal treatment is the procedure in which diseased tissue is removed from inside the tooth. The root canal is cleaned, shaped, sterilized, filled and sealed to prevent further infection and/or loss of the tooth. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, so it *cannot be guaranteed*. Occasionally a tooth which has had root canal therapy may require retreatment, surgery or even extraction.

Risks of treatment are of two kinds: those risks involved in dental procedures in general, and those risks specific to endodontic treatment.

PLEASE DO NOT BE ALARMED BY THE FOLLOWING INFORMATION. MOST COMPLICATIONS ARE QUITE RARE.

RISKS OF DENTAL PROCEDURES IN GENERAL: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedations, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, thrombophlebitis (inflammation to a vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues, referred pain to the ear, neck and head, nausea, vomiting, allergic reactions, itching, bruises, delayed healing, sinus complications, and further surgery. Medications and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, until recovered from their effects. Antibiotics may interfere with the effectiveness of birth control pills.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY: These risks include instruments broken within the root canals, perforations 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 cracked teeth. During treatment, complications may be discovered which make treatment impossible, or which may require dental surgery. These complications may include: blocked canals due to fillings, prior treatment, natural calcification, broken instruments, curved roots, periodontal disease (gum disease) or fractures of the teeth. Surgical complications may occur which include numbness of the lip, cheek, chin, or tongue and/or chronic sinus problems.

THE OTHER TREATMENT CHOICES include: no treatment, waiting for more definite development of symptoms, having the tooth removed. Risks involved in these choices might include pain, swelling, infection, loss of tooth, and infection to other areas.

Please understand that upon completion of root canal therapy in this office you will be directed to return to your general dentist for permanent restoration such as a crown, or filling.

I, the undersigned, being the patient (parent or guardian of minor patient), consent to the performing of the procedures decided upon to be necessary or advisable in the opinion of the doctor. I further, understand and agree to the financial policies described above.

Patient / Parent / Guardian ____ **Date** ________________________