PATIENT MEDICAL HISTORY

First Name:	Last Name:	M.I.:	AKA:	DOB:
Gender:	SSN (if using Insurance):	Email:		
Cell Phone:	Home Phone:	Occupation:		
Address:				
Employer Name:	Pharmacy & Location:			
Referring Doctor:	General Dentist:	Physician:		
Insurance Company:	Subscriber:	Sub. DOB:		

	Yes	No
1. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If yes, please explain:		
2. Has there been any change in your general health within the past year? If yes, please explain:		
3. Are you under the care of a physician for a current problem? If yes, explain:		
4. Have you been hospitalized within the past 2 years? Please specify:		
5. Are you taking any medications? Please list:		
6. Are you ALLERGIC to any medications (penicillin, sulfa, aspirin, etc.)? Explain:		
7. Have you had abnormal bleeding with previous extractions, surgery, or trauma?		
8. Have you ever required a blood transfusion?		
9. Have you ever had surgery and/or radiation for a tumor, growth, or other condition?		
10. Have you ever tested positively for HIV infection or AIDS? If so, state date diagnosed and treating doctor.		
11. Are you required to take antibiotics prior to dental treatment?		
12. **Women only:** are you pregnant, nursing or on birth control pills?		
13. Are you taking any herbal medicine (i.e., St. John's Wort)?		
14. Have you ever taken the "fen-phen" diet?		
15. Do you/ have you ever taken bisphosphanates (ie. Boniva)? If yes, have you stopped? Date of stop:		

Do you have/have you had any of the following? Check all that apply:

- ☐ High blood pressure
- ☐ Heart murmur or prolapsed valve
- ☐ Joint prosthesis (hip, knee, etc.)
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Congenital heart disease
- ☐ Cardiovascular disease: heart attack, stroke or bypass
- ☐ Prosthetic heart valve
- ☐ Blood disorder (e.g. anemia)
- ☐ Venereal disease
- ☐ Asthma
- ☐ ALLERGY TO LATEX
- ☐ Sinus trouble
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Stomach ulcers, colitis
- ☐ Hepatitis, jaundice, liver disease
- ☐ Psychiatric treatment
- ☐ Fainting spells or seizures
- ☐ Epilepsy
- ☐ Cancer
- ☐ Temporomandibular joint problems (TMJ)
- ☐ Low blood sugar

☐	Low blood pressure	☐	Dialysis
☐	Chest pain, angina	☐	Irregular heart beat
☐	Swollen ankles, arthritis or joint disease	☐	Contagious diseases
☐	Cardiac pacemaker	☐	Bronchitis, chronic cough
☐	Heart surgery	☐	Hay fever or sinus problems
☐	Delay in healing	☐	Problems with the immune system
☐	Tuberculosis	☐	Difficult breathing or other lung trouble
☐	Emphysema	☐	Chronic fatigue or night sweats
☐	X-Ray treatment or chemotherapy	☐	History of drug abuse
☐	On a diet	☐	Wear contact lenses
☐	History of alcohol abuse	☐	Bruise easily
☐	Eye disease or glaucoma	☐	Gallbladder trouble
☐	Infectious mononucleosis	☐	None of the above

16. Is there any condition concerning your health (not mentioned above) that the doctor should know about? If yes, please specify:		
17. Do you wish to speak to the doctor privately about anything?		

Inury:

This visit is related to an accident: YES / NO	Work related: YES / NO	Date of injury:
Insurance company handling the claim:		Claim #:

PAIN HISTORY

Tooth #: _____

1. Are you in pain now? ☐ Yes ☐ No

2. Have you experienced pain in this tooth any time in the past? ☐ Yes ☐ No

3. Can you locate the tooth that is causing the pain? ☐ Yes ☐ No ☐ Not sure ☐ There may be more than 1 tooth

4. Does the pain radiate to other parts of your jaw or down your neck and shoulders?
☐ Yes ☐ No ☐ Not now, but has in the past

5. Is the pain spontaneous or does it always require some stimulus to be painful? ☐ Spontaneous pain
☐ It always takes some stimulus to make it hurt
☐ I don't have spontaneous pain now, but have in the past with this tooth

6. Do you feel swollen now? ☐ Yes ☐ No
Any history of prior swelling? ☐ Yes ☐ No
No Are you running a fever? ☐ Yes ☐ No

7. Is the tooth sensitive to temperature?
☐ Yes ☐ No ☐ No, but history of it in past
☐ More to hot than cold ☐ Equally to hot/cold
☐ Neither ☐ Not sure ☐ More to cold than hot

8. Has there been any recent restorative work done on this area? ☐ Yes ☐ No ☐ Not sure

9. Prior to this appointment has endodontic treatment been started by any doctor?
☐ Yes ☐ No ☐ Not sure

10. Have you ever had any endodontic surgery (apico) on this tooth? ☐ Yes ☐ No ☐ Not sure

______________________________ __________
Signature Date

____
Name of Person Completing Form

Financial Policy

Thank you for choosing Aspen Endodontics for your endodontic needs. Our primary goal is to deliver the best endodontic care available in a comfortable and caring environment. We appreciate your trust and confidence in our office and look forward to making your experience as pleasurable as possible.

An important part of our service to our patients is to help make the financial aspect of your dental needs as easy and manageable as possible by offering several payment options. We accept Cash, Check, Visa, MasterCard, Discover, American Express and CareCredit. Payment is expected on the date of service.

If you have dental insurance, we will work with your insurance company to help you maximize your benefits. We are happy to submit the necessary paperwork for you to your insurance carrier for payment. It is important to understand that most dental plans will pay for only part of the cost of your treatment. This will be based on your individual policy and specific benefit package. Because each dental plan is unique and has its own fee schedule for various types of dental treatment, it is impossible to know exactly how your treatment will be covered until the claim is submitted and reviewed by your carrier. We will do everything we possibly can to contact your insurance company to verify your benefits and give you an estimate of how they will pay for your treatment and what your patient portion will be. Whether we obtain this information from your insurance company by telephone, the internet or through the mail, your insurance company does not guarantee coverage and payment for services rendered until the claim is actually submitted and reviewed. It is important to understand that your dental coverage is an agreement between you and your insurance company and that the information we provide you regarding your dental coverage is simply an estimate and is based on information we obtain from your insurance company. If, after receiving payment from your insurance, there is a difference in our estimate, we will refund any credit due or bill you for any balance remaining. If we have not received payment from your insurance company within 60 days of submitting your claim, you will be responsible for full payment of the account for services received. We trust that you understand that we are providing services to you and that you, not your dental insurance, are ultimately responsible for payment of services you receive in our office, regardless of the estimated insurance information we provide you. We ask that you pay your estimated patient portion at the time of service. If you have questions or concerns regarding your insurance benefits, we recommend that you refer to your policy and/or call your insurance company directly.

If you have any questions or unusual financial circumstances, please consult our financial coordinator prior to treatment. If you are unable to make your estimated payment on the date of service, we ask that you reschedule your appointment to a time that will be more convenient for you.

The Waterlase/Epic Lasers and Intraorifice Barriers are state-of-the-art technology that we use in our office. Depending on your specific treatment needs they may be used as a part of your endodontic treatment. If the Laser systems are used for your treatment there will be an additional fee of $100.00 per tooth treated that is not covered by your dental insurance. The intraorifice barrier is placed at the completion of treatment as a barrier to seal & protect the roots from any future contamination, at a cost of $60. These 2 fees will not be submitted to insurance, and will be collected directly from you as part of your patient portion.

Our office reserves the right to charge the following fees: $35.00 Returned Check Fee; $65 Missed Appointment Fee (for broken appointments with less than 24 hours' notice); $20.00 Late Fee (per month for outstanding account balances over 30 days); $40.00 Collection Fee (if your account becomes delinquent it may be forwarded to an outside collection agency without notice. If this happens, you will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees and collection agency costs).

By signing below, I verify that I have read, understand and agree to this financial policy and accept financial responsibility for services received at Aspen Endodontics. I have also read and understand the Notice of Privacy Practices.

Signature: ____ Date: ___________________

Non-Surgical Treatment Consent

Endodontic, or root canal, therapy is a treatment performed to attempt to save a tooth that may otherwise require extraction. Options to root canal treatment include, but are not limited to, extraction or no treatment at all. While endodontic therapy is a highly successful treatment, there are many variables that play into the long-term success of the treatment and there can be no guarantees made as to the outcome.

Risks & possible complications of endodontic treatment and local anesthesia include, but are not limited to:

- Swelling, infection, discomfort or pain following treatment (during the initial stages of healing)
- Numbness or tingling of the lip, tongue or gum tissues
- Limited jaw opening or trismus
- Sinus involvement
- Instrument breakage within the root canal, perforation of the tooth or root, missed or untreatable canals
- Loss of tooth structure in gaining access to the canal system of the tooth
- Damage to existing fillings, crowns or bridges, or other restorations which may require replacement by your general dentist, resulting in additional treatment costs to you. Many times, root canal treatment is needed on a tooth that has an existing crown. Whenever possible, we try to save the existing crown and limit your treatment costs by making a small hole through the top or back of the crown, which can generally be restored or filled by your general dentist following the root canal. In the instances where these crowns are made out of porcelain there is always a chance that the porcelain can crack or fracture during or after treatment.

There are times when a tooth that has had a root canal may need to be retreated, require a follow-up surgical procedure or when the tooth may need to be extracted.

The Waterlase/Epic lasers are state-of-the-art technology that we use in our office and, depending on your specific tooth anatomy and treatment needs, may be used for your endodontic treatment. As explained in our office financial policy there will be an additional fee that is not covered by your dental insurance if either of these systems is needed for your treatment.

Most often your tooth will have a temporary filling in it after the root canal treatment has been completed in our office. It is important that you return to your general dentist within 2-4 weeks following completion of the root canal for the permanent restoration, which may include a filling, core build-up, post, crown or bridge. Failure to have the tooth restored by your general dentist within the recommended timeframe can result in contamination of the root canal system which can adversely affect the healing process and may lead to the need to have the root canal retreated or the tooth extracted.

By signing below, you agree that you have read this consent form, have had the opportunity to have any questions or concerns regarding your treatment addressed, and give your consent for Dr. Transtrum or Dr. Ray to perform the recommended endodontic treatment.

Signature: ____ Date: ___________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ____, have received a copy of Aspen Endodontics Notice of Privacy Practices.

_____________________________________ _____________________________________
Print Name Signature

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Date

In order to correlate any correspondence regarding your treatment and/or billing please complete the following:

Aspen Endodontics has permission to correspond with me directly via the following communication methods (select all that apply): ☐ Voicemail ☐ Text ☐ Email ☐ DECLINE communication

Other Authorized Party: ___________________________________ Relation: ___________________________

Authorized party communication via: ☐ Voicemail ☐ Text ☐ Email

Other Phone: ______________________________ Other Email: ______________________________

FOR OFFICE USE ONLY

- ☐ We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify): ____

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