Vienna Endodontics

Patient Information

Name:_____**Date:**_____ **Social Sec. #**_____ **Sex M/F**____

Home Phone:_____Cell Phone:_____**DOB:**_____

Address:_____

City:_____ **St**:_____ **Zip:**_____ **E-Mail**_____

Employer:_____Business Phone:_____

Who may we thank for referring you?_____

Account information (Responsible Party)

Name:_____ Social Sec.#_____

Address:_____**DOB**:_____

Home#_____ Cell#_____ Work#_____

Medical History

Are you under the care of a physician or are you receiving ongoing medical care?
If yes, please explain _____
Name of your physician: _____
Physician's Phone #:_____ Date of last medical visit:_____

Notify in case of Emergency:

Name: _____Phone:_____ Relation: _____

Do you have any artificial joints, heart valves, implants, or prosthesis? **Y / N**

Have you ever been told you need to be pre-medicated prior to dental treatment? **Y / N**

Have you had surgery, x-ray treatment, or chemotherapy for a tumor, growth, or other condition? If yes, please explain: _____

Are you currently taking aspirin or blood thinners, supplements or herbs, etc.? **Y / N**

Do you have a pacemaker? **Y / N**

Are you allergic to Latex? **Y / N**

If female: Are you pregnant? **Y/ N** If Yes, due date: _____

Please list all medications you are taking including prescription and non-prescription medications:

MEDICATION	DOSAGE	HOW OFTEN TAKEN	REASON FOR MEDICATION

Are you allergic to anything? Y/ N/ NOT KNOWN

ALLERGY TO	REACTION

Please circle any present or past illnesses listed below:

Alcoholism	Glaucoma	Liver
Allergies	Head/Neck injury	Mental
Anemia	Heart Disease	Migraine
Asthma	Hepatitis (**Type**:)	Respiratory
Blood Pressure (**High**/**Low**)	Herpes	Rheumatic Fever
Cancer (**Type**:)	HIV+	Sinusitis
Diabetes (**Type**:)	Immunodeficiency	Ulcers
Drug Dependency	Infectious Disease	Venereal Disease
Epilepsy	Kidney	

Dental History

Are you having any dental discomfort at this time? **Y / N**

If yes, please explain: _____

Have you ever had serious trouble with previous dental work?

Does dental work make you nervous? **Y /N**

Have you ever had any abnormal bleeding associated with previous extractions, surgery, or trauma? **Y /N**

If yes, please explain: _____

I understand that, to the best of my knowledge, all of the proceeding answers are true and correct. If I ever have any change in my health or medications, I will inform my health care provider immediately. I hereby give my consent to treatment for myself, or the named patient (of whom I am the parent, legal guardian, or foster parent) to the Vienna Endodontics.

Signature of Patient /Guardian _____Date_____

Notice of Privacy Policy and Patient Acknowledgement

We are committed to providing you with the quality care, including protecting the confidentiality of your personal medical and treatment information. In response to that commitment and in accordance with federal legislation, we would like to provide you with written notification regarding our office privacy policy and the necessary uses and disclosure of your information.

- We may use your information to provide you with treatment. In treating you for a specific condition, we may need to know if you have allergies or are taking any medications that may affect your treatment in our office, or could interfere with medications we may prescribe.

- We may use your information to provide you with quality care. We may need to review your treatment plan with authorized staff and provide information to other healthcare office to insure excellent communication with all of those involved in caring for you.

- We may use your information so that payment for treatment can be processed. Personal information, office visit dates, codes identifying treatment and diagnosis are required for accurate documentation and processing financial information for payment by you and your insurance company.

We may contact you to provide appointment reminders, information regarding your treatment, and to discuss financial information.

We will not, unless required by law, share your protected information with any other agencies without written authorization.

Patient Acknowledgement:

In accordance with federal legislation, I have read and received notice of this privacy policy and understand I do not have to give written permission for these uses of my protected information. I have the right to inspect and copy protected information, to receive confidential communications regarding protected information, to complain if I believe my privacy rights have been violated, and to receive a copy of this Notice of Privacy Policy upon request.

_____	_____	_____
Patient/Guardian Name	**Signature**	**Date**

Financial Agreement:

A guaranteed form of payment in full must be received by the time services are rendered. While we try to do our best to estimate your insurance benefits and co-payments, we cannot guarantee the final payment amounts due to the fact most insurance contracts have limits and/or various degrees of co-payments and benefits. We collect your estimated co-payment at the time of service. As a courtesy we will then bill your insurance company. Your insurance company may take up to 4 weeks to process payment. Any portion not paid by your insurance after 4 weeks will then become your responsibility and payable within 30 days. If the balance owed is not paid within 60 days we will begin the collection process with an outside agency. You will be responsible for the collection fees, as well as your overdue balance.

Signature of Responsible Party:_____Date:_____

Signature Authorization:

I authorize the office of Vienna Endodontics PLLC to keep my signature on file as a guarantee of payment and to charge my credit card account for the balance of the charges not covered by insurance after I have satisfied my **estimated co-payment paid at time of service.**

You will be automatically charged for the remaining balance to your credit card, after the Insurance has paid their portion. Vienna Endodontics can email a receipt upon request.

Cardholder Name:_____

Cardholder Street Address:_____

City:_____State:_____Zip:_____

Card Number:_____Exp:_____ CSC # _ _ _ _

Cardholder Signature:_____Date:_____

Here at Vienna Endodontics, we stay current with the latest technologies and equipment to provide you with the best success with treatment. A **CBCT/3-dimensional radiograph** of the problem area may be necessary to aid in diagnosis and or treatment. **It is the policy of this office to collect for this payment at the time of service.** Not all dental insurance plans cover this procedure, but we will file a claim to your insurance company. If/when payment is received from your insurance company (and overpayment has occurred), a refund will be issued to you. If a credit card was used for payment it will be refunded to the same credit card without notification from this office. If paid by check or cash, a refund check will be issued. **Initial_____**

Authorization for Consultation and Consent to Endodontic (Root Canal) Treatment

As a consenting adult, I request and authorize Vienna Endodontics and other trained assistants that may be involved to participate in diagnosis and treatment of my (or my child's) condition.

Our commitment to you is to provide you with detailed and reasonably complete information about your dental needs, which we diagnose. We will share our diagnostic findings and opinions with you. We welcome all of your questions regarding our proposed treatment and/or as treatment progresses. Towards this aim of a mutual sharing of information we feel it is important to advise you of the reasonably foreseeable risks of endodontic therapy. The following is important information you should consider in making your decision about treatment:

1. Dentistry is not an exact science, and I acknowledge that no guarantees or assurances have been made to me concerning results of my procedure(s).
2. **Final restoration (post/core crown) is necessary to protect tooth following treatment**. It is my responsibility to contact my dentist within 2 weeks for a final restoration. I understand that lack of a proper restoration can and will compromise the success of my endodontic treatment.
3. **Sometimes during a procedure the doctor may decide that related or additional procedure(s) are also necessary**. For example, if canals are extremely curved or calcified, a longstanding infection in the bone, or a metal file separation in the canal, the tooth may necessitate a surgical procedure to resolve the problem. I authorize the doctor to perform such procedures, which are advisable in their professional judgment.
4. I will be given a local anesthetic injection and in rare instances patients have had allergic reactions, adverse medical reactions, and/or temporary or permanent injury to nerves. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment.

I have provided as accurate and complete medical history, including antibiotics, drugs ands medications I am currently taking as well as those I am allergic.

PROCEDURE: ENDODONTIC (ROOT CANAL) TREATMENT Tooth #_____

Although root canal therapy has a very high degree of success, it is a biological procedure, and therefore the results cannot be guaranteed. Many factors influence treatment outcome: patient's general health, bone support of the tooth, oral hygiene and strength of the tooth including fracture lines, shape and condition of root canals. After treatment, the tooth will need a final restoration to protect its function. The final restoration is not part of this discussion or consent.

Treatment may require multiple visits, and it is important to maintain all appointments or infection/re-infection may occur. Between appointments, your tooth must be protected with a temporary filling.

Mild discomfort/sensitivity may follow treatment, which is usually controlled with Ibuprofen, Tylenol or prescribed medication if necessary.

I understand the alternative options including: to do nothing or extract the tooth. The consequences of doing nothing might be worsening to the condition, further infection, abscess or cystic formation, swelling, pain, loss of tooth, and or other systemic disease/problems.

Complications of Root Canal Treatment may include but are not limited to:

- Post- treatment disease necessitating re-treatment, root surgery, or tooth extraction
- Post-operative pain, swelling, bruising, and/or restrictive jaw opening
- Separation of an instrument inside the canal during treatment. If it cannot be retrieved, it may be sealed inside the root canal. A surgical procedure (apicoectomy) may also be necessary to address the problem.
- Perforation of the tooth or tooth root by instrument or disease, which may require additional surgical procedure or result in tooth loss.
- Damage to soft tissues, sinuses, or nerves resulting in temporary or possibly permanent numbness, and tingling of lip, chin, or other areas.
- **Fractures/cracks of the crown or root during or after treatment are possible, and are a main reason for treatment failure.** Unfortunately, some cracks that extend down the root are invisible and hard to detect. Whether fracture occurs before or after root canal treatment, it may require extraction of the tooth.
- If your tooth has a crown, it is possible it may need to be replaced due to decay, or loss of structural support. Porcelain crowns are subject to breakage.

I have been given an opportunity to ask questions about my condition, alternative treatment, types of anesthesia and risks. I have elected to undergo root canal treatment. I understand there are no guarantees that the proposed treatment will be successful, and I understand the treatment and risks of such treatment. Alternatives have been explained, the consequences of doing nothing, and the fee(s) involved. I certify that I have read and understand the preceding Consent, and/or have asked and had answered to my satisfaction, any and all questions that I may have by my treating dentist.

_____	_____	_____
Print Patient/ Guardian Name	Patient Signature	Date