Active Care ENDODONTICS

Patient Information

Date: _____

First Name: _____ **Last Name:** _____

Preferred Name / Nickname: _____ Parent/legal guardian name: _____

Birth Date: _____ Marital Status: _____ Social Security#: _____

Driver's License Number: _____ State: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

In case of emergency, who should be notified? _____ Phone: _____

Patient Employed By: _____ **Phone:** _____

Business Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Spouse's Name: _____ **Birth Date:** _____

Spouse / Parent Social Security: _____

Spouse Employed By: _____ Phone: _____

Business Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Person responsible for this account: _____

Dental Insurance Company: _____ Policy Holder: _____

Whom may we thank for referring you? _____

Names of General Dentist: _____

Reason for your visit: _____

Health History

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Patient First Name:_____ **Last Name**:_____

Physician's Name: _____ *Date of Last Medical Visit:* _____

Mark a "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ YES	☐ NO	Hepatitis, Type:_____	☐ YES	☐ NO
Anemia	☐ YES	☐ NO	Herpes	☐ YES	☐ NO
Arthritis, Rheumatism	☐ YES	☐ NO	High Blood Pressure	☐ YES	☐ NO
Artificial Heart Valves	☐ YES	☐ NO	Jaundice	☐ YES	☐ NO
Artificial Joints (Hip/Knee)	☐ YES	☐ NO	Kidney Disease	☐ YES	☐ NO
Date:_____			Liver Disease	☐ YES	☐ NO
Asthma	☐ YES	☐ NO	Low Blood Pressure	☐ YES	☐ NO
Back Problems	☐ YES	☐ NO	Mitral Valve Prolapse	☐ YES	☐ NO
Bleeding abnormally, with	☐ YES	☐ NO	Nervous Conditions	☐ YES	☐ NO
Extractions or surgery			Pacemaker	☐ YES	☐ NO
Blood Disease	☐ YES	☐ NO	Psychiatric Care	☐ YES	☐ NO
Cancer	☐ YES	☐ NO	Radiation Treatment	☐ YES	☐ NO
Chemical Dependency	☐ YES	☐ NO	Respiratory Disease	☐ YES	☐ NO
Chemotherapy	☐ YES	☐ NO	Rheumatic Fever	☐ YES	☐ NO
Circulatory Problems	☐ YES	☐ NO	Scarlet Fever	☐ YES	☐ NO
Congenital Heart Lesions	☐ YES	☐ NO	Shortness of Breath	☐ YES	☐ NO
Cortisone Treatments	☐ YES	☐ NO	Sinus Trouble	☐ YES	☐ NO
Cough, persistent or bloody	☐ YES	☐ NO	Skin Rash	☐ YES	☐ NO
Diabetes, Type:_____	☐ YES	☐ NO	Stent Placement	☐ YES	☐ NO
Diarrhea (Cronic or Acute)	☐ YES	☐ NO	Stroke	☐ YES	☐ NO
Emphysema	☐ YES	☐ NO	Swollen Feet or Ankles	☐ YES	☐ NO
Epilepsy	☐ YES	☐ NO	Swollen Neck Glands	☐ YES	☐ NO
Fainting or dizziness	☐ YES	☐ NO	Thyroid Conditions	☐ YES	☐ NO
General Allergies (Latex,Iodine,Etc.)	☐ YES	☐ NO	Tonsillitis	☐ YES	☐ NO
Glaucoma	☐ YES	☐ NO	Tuberculosis	☐ YES	☐ NO
Headaches/Migraine	☐ YES	☐ NO	Ulcer	☐ YES	☐ NO
Heart Murmur	☐ YES	☐ NO	Venereal Disease	☐ YES	☐ NO
Heart Conditions	☐ YES	☐ NO	Weight loss, unexplained	☐ YES	☐ NO

Note any disease, condition or problem not listed above_____

Have you ever been asked to take an antibiotic one hour before a routine dental visit? ☐ Yes ☐ No

Curent Height _____ Weight _____

Are you pregnant? ☐ Yes ☐ No Due Date: _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (or Parent)_____ Date_____

FOR OFFICE USE **Date:**_____ **BP:**_____ **Pulse:** _____ **Initials:**_____

Medication Questionnaire

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Patient Name _____

MEDICATIONS: Are you currently taking any medications? ☐ No ☐ Yes If so, please list them below (include any antibiotics or pain medications)

Name	Strength	Reason Taken	How Often

DRUG ALLERGIES: Are you allergic to any medications? ☐ No ☐ Yes If so, please list them below

Medication Name	Reactions

Patient (or Guardian) Signature _____ Date _____

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Tell Us About Your Dental Symptoms

Patient First Name:_____ **Last Name:**_____

1. Are you experiencing any pain at this time? If not, please go to question 6. Yes ___ No ___

   If yes, can you locate the tooth that is causing the pain? Yes ___ No ___

2. Are you currently taking an pain medications or antibiotics? Yes ___ No ___

   If yes, what? _____

3. When did you first notice the symptoms? _____

4. Did symptoms occur suddenly or gradually? _____

5. Please check the frequency and quality of the discomfort, and the number that most closely reflects the intensity of your pain:

LEVEL OF INTENSITY	FREQUENCY	QUALITY
1 = Mild, 10=Severe	____ Constant	____ Sharp
	____ Intermittent	____ Dull
1___ 2___ 3___ 4___ 5___ 6___ 7___ 8___ 9___ 10 ___	____ Momentary	____ Throbbing
	____ Occasional	

   Is there anything you can do to relieve the pain? Yes ___ No ___

   If yes, what? _____

   Is there anything you can do to cause the pain to increase? Yes ___ No ___

   If yes, what? _____

   When eating or drinking, is your tooth sensitive to: Hot ____ Cold ____ Sweets ___

   Does your tooth hurt when you bite down or chew? Yes ___ No ___

   Does it hurt if you press the gum tissue around this tooth? Yes ___ No ___

   Does a change in posture (lying down or bending over) cause your tooth to hurt? Yes ___ No ___

6. Has a restoration (filling or crown) been placed on this tooth recently? Yes ___ No ___

7. Prior to this appointment, has a root canal therapy been started on this tooth? Yes ___ No ___

8. Do you grind or clench your teeth? Yes ___ No ___

If yes, do you wear a night guard? Yes ___ No ___

10. Is there anything else we should know about your teeth, gums or sinuses that would assist us in our diagnosis?

_____

Signature of Patient (or Guardian) Date_____

Endodontic (Root Canal) Informed Consent

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We not only care about your Endodontic and Dental health, but also about you as a patient to make the treatment decision that you feel is best for you. We will share our findings with you and we welcome all of your questions regarding our treatment. It is important to tell you of the reasonably foreseeable risks of Endodontic treatment. The following is important information you should consider to help with your treatment decision.

1. The purpose of root canal therapy is to retain teeth that would otherwise have to be extracted.
2. Treatment may require multiple visits and only necessary x-rays will be taken. It is important that you maintain your scheduled appointments or an infection can occur or reoccur.
3. In most cases there is mild discomfort following each treatment. This is usually controlled by aspirin, Tylenol, ibuprofen or prescribed medication.
4. Endodontic treatment has a high degree of success. As with any medical or dental treatment, however, this treatment has no guarantee of success for any length of time. Teeth with previous root canal treatment will have a lower success rate. Despite our best efforts, it is estimated that approximately 5% of endodontic treatments may fail and require extraction.
5. Accurate and complete disclosure of medical information is necessary for proper diagnosis and to help prevent unnecessary complications during your treatment.
6. Complications with root canal therapy may include but are not limited to:
    a. The use of local anesthetic agents and its application may have certain risks. Both local and/or systemic.
    b. Continued infections, calcified canals, blocked canals, and/or the separations of instruments during treatment may require endodontic (root canal) surgery or extraction of the tooth.
    c. Fractures (breaking) of the root or crown of the tooth can occur during or after treatment. It is recommended that all posterior teeth be crowned following root canal treatment. If your tooth already has a crown, there is a chance it will need to be replaced due to decay or loss of structural support. Your general dentist will make the final determinations as to whether the crown can be saved. Porcelain crowns are subject to breakage.
    d. Pain, requiring the use of medication, that may bring side effects and reactions - to this medication. (Please familiarize yourself with them)
    e. Tenderness of the tooth following treatment can be due to possible complications, gum disease, physical stress from chewing of the degree of healing your body exhibits.
7. Other treatment choices include: No treatment, waiting for more definite development of symptoms, and tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth and infections to other areas.
8. Upon completion of the root canal treatment, we strongly recommend you return to your general dentist within 30 days. He will determine the final restoration. This may include, but not be limited to, a crown or other permanent filling material.
9. I understand that I may ask Dr. Giraldo any questions I may have regarding endodontic treatment to my satisfaction.

I have read and understand the above and hereby consent to treatment

Signature of Patient (or Guardian) _____ Date _____

Patient Name _____ Witness _____

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Financial Arrangements

Payment Options (Please Circle One)

1. Cash or check payment in full at time of service
2. Mastercard or Visa at time of service

I agree to:

A. A $30.00 charge on all returned checks

B. I understand that I am responsible for any debt regardless of my insurance

C. To pay 1.5% per month on any unpaid balance that extends beyond 60 days

D. In the event that my account is not paid as agreed I agree to pay a collection fee of 33% of my unpaid balance in addition to my balance. In the event that it is necessary to commence legal action to collect my account, I agree to pay reasonable attorney's fees and/or cost of court collection.

Signature of responsible person _____

Today's date _____

Witness _____

J. Mauricio Giraldo, DMD
1745 South Kings Ave.
Brandon, Florida 33511

I understand that I have certain rights to privacy regarding my protected health information. These are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatments (including direct or indirect treatment by other healthcare providers involved in my treatment.)
- Obtaining payment from third party payers (e.g. my insurance company):
- The day-to-day healthcare operations of your practice.

II have also been informed of and given the right to review and secure a copy of the *Notice of Privacy Practices*, which contains a more complete description of the issues and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but you are not required to agree to these requested restrictions. However, if you do agree, you are bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____ 20_____.

Print Patient Name _____

Relationship to Patient _____

Signature _____