PATIENT MEDICAL HISTORY

First Name:	Last Name:	M.I.:
Home Phone:	Cell Phone:	DOB:
Home Address:	City/State/Zip	
Employer:	E-mail:	
Employer Address:	City/State/Zip:	
Referring Doctor:	Family Dentist:	
Family Physician	Family Physician Phone:	
Emergency Contact and Phone Number:		

	YES	NO
Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If yes, Please explain.		
Has there been any change in your general health within the past year? If yes, please explain.		
Are you under the care of a physician for a current problem? If yes, explain.		
Have you been hospitalized within the past 5 years? Please specify.		
Are you taking any medication or drugs? List on page 2		
Have you ever had any **ALLERGIC or ADVERSE REACTIONS** to anesthetics/antibiotics/ Medications? Please specify.		
Is there any condition concerning your health that the doctor should be told?		
Have you had abnormal bleeding with previous extractions, surgery, or trauma?		
Have you ever required a blood transfusion?		
Have you ever had surgery and/or radiation for a tumor, growth, or other condition?		
Have you ever tested positive for HIV infection or AIDS? If so, state date diagnosed and treating doctor.		
Are you required to take antibiotics prior to dental treatment?		

Do you have or have you had any of the following? Check box that applies.

- ☐ High blood pressure
- ☐ Heart murmur or prolapsed valve
- ☐ Joint prosthesis (hip, knee, etc.)
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Congenital heart disease
- ☐ Sinus trouble
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Stomach ulcers, colitis
- ☐ Hepatitis, jaundice, liver disease

- ☐ Cardiovascular disease: heart attack, stroke
- ☐ Prosthetic heart valve
- ☐ Blood disorder (e.g. anemia)
- ☐ Venereal disease
- ☐ Asthma
- ☐ Allergy to latex
- ☐ Low blood pressure
- ☐ Chest pain, angina
- ☐ Swollen ankles, arthritis or joint disease
- ☐ Cardiac pacemaker
- ☐ Heart surgery
- ☐ Delay in healing
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ X-Ray treatment or chemotherapy
- ☐ On a diet
- ☐ History of alcohol abuse
- ☐ Eye disease or glaucoma
- ☐ Infectious mononucleosis
- ☐ Psychiatric treatment
- ☐ Fainting spells or seizures
- ☐ Epilepsy
- ☐ Cancer
- ☐ Temporomandibular joint problems (TMJ)
- ☐ Low blood sugar
- ☐ Dialysis
- ☐ Irregular heartbeat
- ☐ Contagious diseases
- ☐ Bronchitis, chronic cough
- ☐ Hay fever or sinus problems
- ☐ Problems with the immune system
- ☐ Difficult breathing or other lung trouble
- ☐ Chronic fatigue or night sweats
- ☐ History of drug abuse
- ☐ Wear contact lenses
- ☐ Bruise easily
- ☐ Gallbladder trouble

Please specify any conditions not listed:

Please list medications that you are currently taking:

Women only:

Possibility of pregnancy:	YES / NO	Nursing:	YES / NO
Estimated delivery date:		Taking birth control pills:	YES / NO

Antibiotics (such as penicillin) may alter the effectiveness of birth control pills.

Injury:

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

Patient Signature (Parent signature if patient is under 18 years of age). Date:

Dana Point Endodontics
24981 Dana Point Harbor Drive, Suite E-120
Dana Point, CA 92629

Office Financial Policy

Those without dental insurance:
The total fee of the evaluation and/or treatment is due at the time service is provided.

Those with dental insurance:
As a courtesy we will process all of your dental insurance claims. All charges you incur are your responsibility. We will provide an insurance estimate to you, payment is required of the estimated patient portion at the time of service. We will do all we can to ensure your estimate is as accurate as possible. It is not a guarantee that your insurance company will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid, it is a contract between you and your insurance company. In some cases when insurance information is not available, all charges will be due at the time of service. We will process your dental claim on your behalf and payment from your insurance company will be sent directly to you.

- If your insurance pays **more** than the estimated amount, a refund check from our office will be mailed to you within 1 month from the date payment is received. We usually batch them at the end of the month.

- If your insurance pays **less** than the estimated amount, you will receive a statement from our office. We usually do not send monthly statements so prompt attention is greatly appreciated.

Patient Signature: _____ Date:_____

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CONSENT FOR ENDODONTIC THERAPY

The purpose of this form is to tell the risks that may occur during endodontic (root canal) treatment. You will be required to sign this form prior to the initiation of treatment. Your signature does not commit you to any treatment. Root canal treatment is done in order to retain a tooth for as long as possible which otherwise might need to be removed. Like any medical procedure, treatment outcome is multifactorial and variable. During treatment, complications may be discovered which make treatment impossible, reduce the success rate, or which may require dental surgery. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth, which has had a root canal procedure, may require retreatment, surgery, or even extraction.

Alternatives to endodontic treatment include no treatment, waiting for increased development of symptoms, tooth extraction and obtaining a second opinion. Risks involved in these choices might include pain, swelling, infection, loss of tooth, and spread of infection to other areas.

THERE ARE CERTAIN INHERENT AND POTENTIAL RISKS IN ANY TREATMENT PLAN OR PROCEDURE. I UNDERSTAND THAT THE FOLLOWING MAY BE INHERENT OR POTENTIAL RISKS FOR THE TREATMENT I WILL RECEIVE: Swelling; fever; infection; bleeding; bruising; discoloration of the face; pain; sensitivity; transient or permanent nerve damage, resulting in tingling, numb or burning sensation in the lip, tongue, chin, gums, cheeks and teeth; changes in occlusion (biting); jaw muscle cramps and spasm; temporomandibular joint (TMJ) problems, including discomfort, dysfunction and clicking or popping; loosening of teeth, damage to existing restorations including bridges, fillings, crowns or veneers, on the tooth receiving endodontic therapy or other teeth or dental implants; loss of tooth structure in gaining access to canals, weakening of teeth, tooth perforations, cracked teeth; delayed healing; treatment failure; sinus perforations; complications resulting from the use of dental instruments and materials including broken instruments retained in the tooth or surrounding tissues and extrusion of root filling material into surrounding tissues including the sinus or inferior alveolar nerve; reactions to injections; complications from and reactions to anesthetics and medications, causing allergy, drowsiness and lack of coordination; and antibiotics may inhibit the effectiveness of birth control pills.

All of my questions have been answered and I fully understand the above statements in this consent form.

Note: All medical records will be kept strictly confidential

If patient is under the age of 18, the signature of a parent or guardian is required.

Patient Signature: _____ Date: _____

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Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Our Legal Duty:

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make a new notice available upon request.

Uses And Disclosures of Health Information:

We use and disclose health information about you for treatment, payment and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose.
Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.
Required by Law: We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages and text message).

Patient Rights:

Access: You have the right to look at or get copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You may obtain a form to request access by using the contact information. We will not charge you for copies and staff time of your health information.
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associate disclosed your health information for purpose, other than treatment, payment, healthcare operations and other activities.
Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement except in an emergency.
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (you must make your request in writing.) Your request must specify the alternative means or location and provide a satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.
Electronic Notice: If you receive this notice on our web site or by e-mail, you are entitled to receive this notice in written form.

Questions and Complaints:
If you want more information about our privacy or have questions or concerns, please contact us.
If you are concerned that we may have violated our privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by an alternative means or at alternative locations, you may complain to us using the contact information at the top of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Patient Signature: _____ Date: _____