KATY ENDODONTIC ASSOCIATES, L.L.P.

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. Let us know if we can be of any assistance. We look forward to working with you.

Last name | First name | Initial | Birth date | Social Security Number | Home Phone

Gender: ❑ Male ❑ Female *Please check one*: ❑ Minor ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Address | Apt. No. | City | State | ZIP Code

Patient's Employer | Occupation | Business Phone | Mobile Phone

Name of Spouse/Parent | Spouse/Parent Employer | Patient/Guardian Email Address

Dental Insurance Company | Group Name and Number | Phone

Insured/Policy Holder Name | Insured's Social Security Number | Insured's Birth Date

Family Dentist | Referred By:

Chief Dental Complaint: _____

Is this your first visit to our office? ❑Yes ❑ No If no, approximately what year was your last visit? _____

Please list your pharmacy information including the name, address & phone number below.

_____

Medical History

Circle the answer that applies. *If you are uncertain, please mention it to the doctor.*

Yes	No	Are you presently under a physician's care?	Yes	No	Have you ever had hepatitis? If yes when? _____
Yes	No	Physician's Name: _____	Yes	No	Have you ever been tested for HIV (AIDS) antibodies?
Yes	No	Have you ever had an abnormal reaction to any medications? List: _____			If yes, when? _____ Results: ❑ Positive ❑ Negative
Yes	No	Do you have any other allergies? List:_____	Yes	No	Have you ever been hospitalized? If yes, when? _____
Yes	No	Are you sensitive to latex or rubber?	Yes	No	Have you ever had a hip or joint replacement? If yes, when? _____
Yes	No	Do you suffer from asthma or hay fever?	Yes	No	Have you previously had endodontic (root canal) treatment?
Yes	No	Have you ever had rheumatic fever?	Yes	No	Have you had psychiatric care?
Yes	No	Do you have heart trouble?	Yes	No	Do you have mitral valve prolapse or ballooning?
Yes	No	Has your physician prescribed any drugs for you to take for: gland trouble, heart trouble, epilepsy, to prevent blood clots, or for allergies?	Yes	No	Women: Are you taking birth control medication? If yes, antibiotics may reduce the effectiveness of birth control pills.
Yes	No	Have you ever had Tuberculosis or other lung problems?	Yes	No	Women: Are you pregnant? If so, how many months? _____
Yes	No	Have you ever had trouble after an injection?	Yes	No	Are you taking any medications at this time? Please list ***ALL*** medications you are currently taking (prescription and over-the-counter). _____
Yes	No	Do you have diabetes?	Yes	No	Have you ever had radiation treatment for tumors?
Yes	No	Have you ever had thyroid trouble?	Yes	No	Do you have high blood pressure?
Yes	No	Do you have ulcers?	Yes	No	Have you ever had kidney disease?
Yes	No	Do you take a blood thinner?	Yes	No	Do you get out of breath easily?
Yes	No	Are you anemic?	Yes	No	Who filled out this questionnaire? ❑ Patient ❑ Other: Name_____ Relationship _____

Signed_____ Date_____

Subsequent visits:

Reviewed, Updated, & Signed _____ Date _____

Endodontic Information and Consent Form

Endodontic (Root Canal) Treatment, Endodontic Surgery, Anesthetics, and Medications

We would like our patients to be informed about the various procedures involved in endodontic treatment and have their consent before starting treatment. Endodontic (root canal) treatment is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by conservative root canal treatment, or, when needed, endodontic surgery. The following discusses possible risks that may occur from endodontic treatment and other treatment choices.

General Risks

Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections. These complications include: swelling; sensitivity; bleeding; pain; infection; numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is transient (temporary) but on infrequent occasions may be permanent; reactions to injections; changes to occlusion (biting); jaw muscle cramps and spasms; temporomandibular (jaw) joint difficulty; loosening of teeth; referred pain to ear, neck and head; vomiting; allergic reactions; delayed healing; sinus perforations; and treatment failure.

Risks More Specific to Endodontic (Root Canal) Treatment

The risks include the possibility of instruments broken within the canals; perforations (extra openings) 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 or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), splits or fractures of teeth.

Medications

Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives, or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effects.

Alternative Treatments

These treatments include no treatment, waiting for more definite development of symptoms, and tooth extractions. Risks involved in the choices might include pain, infection, swelling, loss of teeth, and infection of other areas.

Consent

I, the undersigned, the patient (parent or guardian of minor patient) consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. I also understand that upon completion of the root canal treatment in this office, I shall return to my general family dentist for a permanent restoration of the tooth involved, such as a crown, cap, jacket, onlay or filling. I understand that root canal treatment is an attempt to save a tooth that may otherwise require extraction. Although root canal treatment has a high degree of success, it cannot be guaranteed. Occasionally, a tooth that has had root canal treatment may require retreatment, surgery, or even extraction. Finally, I authorize the insurance company indicated on this form to pay this office all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize this office to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due in full at time of treatment unless, prior arrangements have been approved.

Patient/Parent/Guardian Signature	Date
Patient/Parent/Guardian Name (Print)	Witness

KATY ENDODONTIC ASSOCIATES, L.L.P.

23410 Grand Reserve Drive. Bldg. 5, Suite 505 Katy, Tx 77494
Voice (281) 693-3200, Fax (281) 693-6303

Patient Consent For Use and Disclosure of Protected Health Information

With my consent, Katy Endodontic Associates, L.L.P. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Katy Endodontic Associates, L.L.P. Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Katy Endodontic Associates, L.L.P. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to:

Katy Endodontic Associates, L.L.P. Privacy Officer at 1150 South Mason Road,
Suite 102, Katy, TX 77450

With my consent, Katy Endodontic Associates, L.L.P. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Katy Endodontic Associates, L.L.P. may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Katy Endodontic Associates, L.L.P. may e-mail to me appointed reminder cards and patient statements. I have the right to request that Katy
Endodontic Associates, L.L.P. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions,
but if it does, it is bound by this agreement.

By signing this form, I am consenting to Katy Endodontic Associates, L.L.P. use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing
except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Katy Endodontic Associates L.L.P.,
may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Patient's Name

_____ _____

Print Name of Patient or Legal Guardian Date