Chart #_____ Palisades Endodontics Stephen J. Tsoucaris DMD

A: MEDICAL HISTORY

Patient Name:_____ Date of Birth:_____ SS#:_____

Address:_____ City/State/Zip:_____

Phone #:_____E-mail:_____ Referred By:_____

Dentist Name & Telephone #:_____

Please complete the following questions in order that we may thoroughly diagnose your condition. The information you provide is for our records and will be considered strictly confidential.

1. Has there been any change in your general health within the past year? YES NO
   Please specify _____
2. Are you under the care of a physician for a current problem? YES NO
   Please specify _____
3. Have you been hospitalized within the past 5 years? YES NO
   Please specify _____
4. Are you taking any medications or drugs? YES NO
   Please specify _____
   Have you received therapy for alcoholism or drug addiction within the past 5 years? YES NO
5. Have you ever had any ALLERGIC OR ADVERSE REACTIONS to anesthetics, antibiotics, or other medications?_____ YES NO
6. Have you had abnormal bleeding with previous extractions, surgery, or trauma? _____ YES NO
7. Have you ever required a blood transfusion? Please explain_____ YES NO
8. Have you ever had surgery and/or radiation for a tumor, growth, or other condition? _____ YES NO
9. Do you have any condition which is infectious? _____ YES NO
10. Date of your last physical exam _____ Name of Dr.:_____
11. Do you have any disease or condition, or problem not listed above? Please specify _____ YES NO
12. Are you required to take antibiotics prior to dental treatment? YES NO
    If you answered Yes, be advised that if you take antibiotics, an alternate method of birth control must be used.
13. ***Are you allergic to any medication?** _____ YES NO
14. Have you ever had a root canal? _____Date:_____How was your experience:_____
15. Are you pregnant?_____Are you nursing?_____ Do you take birth control pills?_____
16. Are you taking or have you taken: Fen-Phen (weight loss medication)?
17. Are you taking or have you taken: Bisphosphonate use (Actonel, Boniva, Evista, Fosamax)?
18. Do you or have you had any of the following: (please circle)

High Blood Pressure	Congenital Heart Disease	Heart Murmur or Prolapsed Valve (MVP)
Heart Attack, Stroke, By-Pass Surgery	Pacemaker	Joint Prosthesis (Hip, Knee, Etc.)
Prosthetic Heart Valve	Blood Disorder (eg: Anemia)	Rheumatic Fever or Rheumatic Heart
Hepatitis, Jaundice, Liver Disease	Kidney Problems	Disease
Stomach Ulcers, Colitis	Fainting Spells / Epilepsy / Seizures	Diabetes
Asthma	Thyroid Problems	Venereal Disease
Psychiatric Treatment	Sinus Trouble	Cancer
		Temporomandibular Joint Problems (TMJ)

EMERGENCY CONTACT: _____**Phone #**:_____

Date:_____BP:_____ P:_____ SaO2:_____

I, _____, have reviewed all of the above medical information and it is correct to the best of my knowledge.

⇒ Signature of Patient*_____ Signature of Doctor_____Date: _____

*All signatures must be by patient or guardian if the patient is under the age of 18.

B: ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

You May Refuse to Sign This Acknowledgement

I, _____, have reviewed a copy of this office's Notice of Privacy Practices.

⇒ Signature of Patient*_____Date:_____

*All signatures must be by patient or guardian if the patient is under the age of 18.

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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement • Other (Please Specify)

C: FINANCIAL CONSENT FORM

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

1. APPOINTMENTS:Because we reserve 1-2 hours for your exclusive use, we require 24 hours notice if you are unable to keep a scheduled appointment. Failure to notify our office of a cancellation will result in a $150.00 broken appointment fee.
2. PAYMENT:**Payment is due in full at the time services are rendered.** We accept cash, personal check, Care Credit, Visa and MasterCard. If payment is not made within thirty days of the office visit, interest of 1.5% per month (18% per year) will be incurred. All balances are due in full within 60 days of service, regardless of insurance company arrangements. Accounts not settled by 60 days will be forwarded to our collection agency. When sent to collection an additional 35 percent will be added to the unpaid balance, and any legal and court fees incurred will be the patient's responsibility. **There will be a $50.00 fee for any returned checks or disputes for credit card payments made.**
3. INSURANCE:As a courtesy, this office provides a computer generated insurance form upon the completion of each visit. You must realize that your insurance is a contract between your employer, and the insurance company. We are not a party to that contract. Furthermore, not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will not cover. You will be responsible for any fees or deductibles not covered by your current insurance carrier. Please refer to your personal policy for this information.

We must emphasize that as a dental care provider, our relationship is with you, not your insurance company. All charges are your responsibility from the date the services are rendered. This office realizes that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us before services are rendered for assistance in the proper management of your account.

If you have any questions about the above information or any uncertainty, PLEASE do not hesitate to ask us. The staff is here to help you.

I, _____, have reviewed a copy of this office's Financial Consent Form.

⇒ Signature of Patient*_____Date:_____

*All signatures must be by patient or guardian if the patient is under the age of 18.

INSURANCE INFORMATION

Do you have dental insurance?_____ Insurance Company:_____

Group #: _____ ID#: _____

Primary Member SS#_____ Primary Member DOB: _____

CREDIT CARD AUTHORIZATION

I authorize Stephen Tsoucaris, D. M. D., PC to keep my signature on file and to charge my card for:

- Balance of charges not paid by insurance, This Visit, All visits
- Recurring Charges of $_____ Every _____ From _____ to _____

I assign my insurance benefits to the provider listed above.

Account #:_____ Expiration: _____/_____ CVC:_____

I understand that this form is valid unless I cancel the authorization by written notice to the health care provider.

Patient Name:_____ Card member name: _____

Card member billing address:_____

⇒ **Signature:** _____ Phone number: _____

D: INFORMED CONSENT FOR ENDODONTICS (ROOT CANAL THERAPY)

Endodontic (root canal) therapy is an attempt to save a tooth that has pulpal disease, which would otherwise be removed. This is usually accomplished by using non-surgical procedures but on occasion surgery is necessary.

ALTERNATE CHOICES TO ROOT CANAL THERAPY: Other treatment choices include: no treatment, waiting for more definitive symptoms to develop or even tooth extraction. Risks involved in these choices might include pain, swelling, loss of teeth, and infection to other areas.

GENERAL RISKS: Resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics, and injections included (but not limited to) complications which may result in swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, which may be transient but on infrequent occasions may be permanent; reactions to injections; changes in occlusion (bite); jaw muscle cramps and spasms; temporomandibular jaw (joint) difficulty; loosening of teeth; referred pain to ear, neck, and head, nausea, vomiting; allergic reactions; delayed healing, sinus perforations and treatment failures.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY: The risks include the possibility of instrument parts separating within the root 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, or 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, previously broken instruments, unusually curved roots, periodontal disease (gum disease) and/or splits or fractures of the teeth.

PRESCRIBED MEDICATIONS: Some 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). If prescribed, it is not advisable to operate any vehicle or hazardous device until you have recovered from their effects.

CONSENT:I, the undersigned, being the patient (parent or guardian of a 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 therapy in this office I shall return to my dentist for a "permanent" (outside) restoration of the tooth involved such as a crown ("cap"), jacket, onlay, or filling. I realize that check-up x-rays should be taken at prescribed intervals by my dentist or the treating endodontist.
I understand that root canal treatment is an attempt to save a tooth, which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth, which has had root canal therapy, may require retreatment, surgery or even extraction. I have carefully read the above statements, my questions have been answered to my satisfaction, and I give my consent to the procedure.

⟹ Signature of Patient*_____ Date:_____

*All signatures must be by patient or guardian if the patient is under the age of 18.

Signature of Doctor:_____ Date:_____

E: ACKNOWLEDGEMENT OF RECEIPT OF POST OP INSTRUCTIONS:

Post Operative Instructions were given to me both orally & in written form: _____Date:_____ Report Sent_____

	Perc	Palp	Perio	ST/HT	Thermal	Start	Finish
Tooth #_____	_____	_____	_____	_____	_____	_____	_____
Tooth #_____	_____	_____	_____	_____	_____	_____	_____
Tooth #_____	_____	_____	_____	_____	_____	_____	_____

Today's Visit	**Next Visit:**
Procedure: _____	Procedure: _____ Date: _____
Fee: _____	Duration: _____ Fee: _____