Manhattan / Gramercy phone: (212) 228-2663
Queens / Astoria phone: (718) 545-7770

ENDODONTIST NYC
www.endodontistnyc.com

Patient Information & Medical History Form: Date:_____

Last:_____ First: _____ **Birth date: _____**
Home address:_____ **SS # :_____**
City / Town:_____ **State:_____Zip:_____**
Home Phone:_____ **Cell phone:_____**
Employer Name:_____ **Work phone: _____**
Dentist:_____ **Personal Physician:_____**
Email address:_____
Pharmacy Name/ Address/ number:_____

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.

	YES	NO
1. Has there been any change in your general health within the year? Please specify:_____	____	____
2. Are you under the care of a physician for a current problem? Nature of treatment:_____	____	____
3. Have you been hospitalized within the past 5 years? Reason:_____	____	____
4. Are you taking any medications or drugs? Please specify:_____	____	____
5. Have you received therapy for alcoholism or drug addiction during the past 5 years?	____	____
6. Have you ever had any **ALLERGIC OR ADVERSE REACTIONS** to Anesthetics? Antibiotics or other medications? Please specify:_____	____	____
7. Have you had abnormal bleeding with previous extractions, surgery, or trauma?	____	____
8. Have you ever required a blood transfusion? Please explain:_____	____	____
9. Have you ever had surgery and/or radiation for a tumor, growth, or other condition?	____	____
10. Do you have any condition, which is infectious?	____	____
11. Are you taking or have you previously taken Bisphosphonate medications, such as Actonel, Fosamax, or Zometa, with the past twelve years?	____	____
12. Date of last physical exam:_____	____	____

13. Do you or have you had any of the following: (please circle)

·HIGH BLOOD PRESSURE	·SINUS TROUBLE	·FAINTING SPELLS OR SEIZURES
·RHEUMATIC FEVER/RHEUMATIC HEART DISEASE	·CARDIOVASCULAR DISEASE (HEART ATTACK, BY-PASS, etc.)	·HEART MURMUR OR PROLAPSED VALVE (MVP)
·TEMPOROMANDIBULAR JOINT PROBLEMS (TMJ)	·JOINT PROSTHESIS (HIP, KNEE, etc.)	·LIVER DISEASE (HEPATITIS/JAUNDICE)
·CONGENITAL HEART DISEASE	·STOMACH ULCERS, COLITIS	·THYROID PROBLEM
·DIABETES (TYPE 1/TYPE 2)	·PACE MAKER	·KIDNEY PROBLEMS
·PSYCHIATRIC TREATMENT	·BLOOD DISORDERS (ANEMIA)	·VENERAL DISEASE
·CANCER	·ASTHMA	·PROSTHETIC HEART VALVE
·STROKE	·EPILEPSY	

14. Do you have any disease, condition, or problem not listed above? Please specify:_____

15. Do you need to **pre-medicate** 1 hour prior to **any** dental treatment	____	____
16. Have you ever had a root canal treatment?	____	____
17. Are you pregnant, nursing, or taking birth control pills?	____	____

If YES, be advised that if you take antibiotics, an alternate method of birth control must be used.

X _____ **X _____** **_____**
Date **Signature of patient** **Signature of Doctor**

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Dr. Cezar M. Mitrut, D.M.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 to the lip, tongue, chin, gums, cheeks and teeth, which may be transient but on infrequent occasions may be permanent; reactions to injections, changes to 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.

Please 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.

CONSENT: I, the undersigned, 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 my dentist or the treating endodontist should take check-ups & x-rays at prescribed intervals.

Signature of Patient or Guardian: **X** _____ Date: **X**_____
Signature of Witness: _____ Date: _____
Signature of Doctor: _____ Date: _____

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

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 checks, Visa, MasterCard, American Express, & Discover. In the event that your account becomes delinquent for more than 30 days, (from the date of treatment completion) you also agree to pay a finance charge of 1.5% per month on any balance due, as well as court costs, attorney fees and interest fees accrued with the collection of your account.

3. **INSURANCE:** As a courtesy, this office provides a computer generated insurance form upon completion of each visit. You must realize that your insurance is a contract between you and/or your employer, and the insurance company. We are not a party to that contract. Furthermore, not all services are covered benefits 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 issues 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, PLEASE do not hesitate to ask us. The staff is here to help you.

I **X** _____ understand and agree to the above on **X** _____.
(Patient's signature) (Date)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
******You may refuse to sign this acknowledgement******

I, **X** _____, have reviewed a copy of this office's Notice of Privacy Practices.
(Please print name)

X _____ **X** _____
(Signature) (Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
(1) Individual refused to sign
(2) Communication barriers prohibited obtaining the acknowledgement
(3) An emergency situation prevented us from obtaining acknowledgement
(4) Other (please specify): _____