WESTFORD ENDODONTIC CARE

PATIENT REGISTRATION & HEALTH HISTORY

PATIENT INFORMATION

Patient Name: _____ Date: _____

Address: _____

Email: _____ Gender: _____

Date of Birth: _____ / _____ / _____ Is the patient a minor (under 18)? Yes ☐ No ☐

Home: (_____) _____ Cell: (_____) _____ Work: (_____) _____ x _____

IN CASE OF EMERGENCY, PLEASE CONTACT: _____

Relationship to Patient: _____ Emergency Contact Number(s): _____

DENTAL INSURANCE

Subscriber's Name: _____

Subscriber's Date of Birth: _____ / _____ / _____ Subscriber's Social Security #: _____

Relationship to Patient: _____

Insurance Company: _____ Subscriber ID: _____

Is the patient covered by additional insurance? Yes ☐ No ☐

Secondary Insurance Company: _____ Subscriber ID: _____

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s) have insurance coverage with _____ insurance company(ies) and assign directly to Westford Endodontic Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Westford Endodontic Care may use my healthcare information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative | Relationship to Patient

_____ _____ / _____ / _____

Printed Name | Date

HEALTHCARE INFORMATION

General Dentist: _____ Reason for today's visit: _____

Physician's Name: _____ Physician Phone: (_____) _____

DENTAL HISTORY

PLEASE CHECK THE BOX TO INDICATE IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Chewing tobacco
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collecting between teeth
- ☐ Foreign objects
- ☐ Grinding or clenching teeth
- ☐ Gums swollen or tender
- ☐ Jaw pain or tiredness
- ☐ Lip or cheek biting
- ☐ Loose teeth or broken fillings
- ☐ Mouth breathing
- ☐ Mouth pain during brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Smoking / Vaping
- ☐ Sores or growths in your mouth

HOW OFTEN DO YOU FLOSS? _____ HOW OFTEN DO YOU BRUSH? _____

HEALTH HISTORY

Do you need to take antibiotics prior to receiving dental care? ☐ Yes ☐ No ☐ Don't know

If Yes, for what condition: _____ Name of antibiotic: _____ Dosage: _____

Have you ever used a bisphosphonate medication? (Fosamax, Actonel, Atelvia, Didronel, Boniva) ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Apidex, Fastin (brand names of Phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine)? ☐ Yes ☐ No

Have you ever been exposed to or tested positive for COVID-19 (Coronavirus)? ☐ Yes ☐ No ☐ Don't know

PLEASE CHECK THE BOX TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

CARDIAC ISSUES
- ☐ Angina Pectoris
- ☐ Artificial Heart Valves
- ☐ Congenital Heart Lesion
- ☐ Heart Murmur/Mitral Valve Prolapse
- ☐ Heart Attack/Myocardial Infarction
- ☐ Heart Failure
- ☐ Heart Surgery
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Pacemaker/AICD
- ☐ Rheumatic/Scarlet Fever
- ☐ Stroke

BLOOD DISORDERS
- ☐ Anemia
- ☐ Bleeding Abnormalities
- ☐ Hemophilia
- ☐ Sickle Cell Anemia

RESPIRATORY
- ☐ Cough
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Tuberculosis

CANCER-RELATED
- ☐ Chemotherapy
- ☐ Radiation Therapy
- ☐ Tumor or Unusual Growth
- ☐ Weight Loss, Unexplained

CHRONIC CONDITIONS
- ☐ Acid Reflux/Heartburn
- ☐ Arthritis, Rheumatoid/Osteo
- ☐ Artificial Joints/Prostheses
- ☐ Cortisone Treatments
- ☐ Diabetes
- ☐ Glaucoma, Type _____
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Substance Use Disorder
- ☐ Thyroid Problems, Type _____

INFECTIOUS DISEASE
- ☐ AIDS/HIV
- ☐ Hepatitis, Type _____
- ☐ Herpes/Cold Sores
- ☐ Skin Rash
- ☐ Swollen Neck/Glands
- ☐ Tuberculosis
- ☐ Venereal Disease

NEUROLOGICAL/COGNITIVE
- ☐ Anxiety
- ☐ Depression
- ☐ Dementia
- ☐ Epilepsy/Seizures
- ☐ Fainting/Dizziness/Vertigo
- ☐ Headaches, Type _____
- ☐ Paralysis/Weakness
- ☐ Psychiatric Care

PAIN CONDITIONS
- ☐ Acute, Type _____
- ☐ Chronic, Type _____
- ☐ **OTHER** Conditions not listed:

_____

_____

_____

FOR WOMEN
- ☐ Pregnant, # weeks: _____
- ☐ Nursing
- ☐ Taking Oral Contraception

MEDICATIONS

Pharmacy Name: _____ Phone: (_____) _____

Pharmacy Address: _____

Please list any medications you are currently taking (including herbal supplements) and the correlating condition:

MEDICATION	CONDITION	DOSAGE

ALLERGIES

PLEASE CHECK THE BOX TO INDICATE IF YOU HAVE AN ALLERGY TO ANY OF THE FOLLOWING:

- ☐ Acetaminophen (Tylenol)
- ☐ Codeine
- ☐ Local Anesthetics
- ☐ Latex
- ☐ NSAIDS (Ibuprofen, Advil, Naproxen, Naprosyn)
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other (please list below)

If you checked yes to any of the above, please decsribe the nature of your allergic reaction below:

_____

_____

_____

NOTES:

B.P. _____ / _____ mmHg, Pulse _____ bpm, Temp _____°F

_____ _____ / _____ / _____

Christopher K. Ross, D.M.D. Date

WESTFORD ENDODONTIC CARE

CONSENT FOR ENDODONTIC THERAPY

Please review the following consent. You will be required to sign it prior to the initiation of treatment.

This is my consent to authorize Dr. Christopher K. Ross to perform endodontic therapy on tooth/teeth #(s)_____. I further give my consent for Dr. Christopher K. Ross to take my radiographs (x-rays), administer any medications, anesthetics, drugs and services or procedures that he deems necessary or advisable as a corollary to the planned endodontic treatment.

I understand that endodontic therapy is a procedure to retain a tooth that may otherwise require extraction. Endodontic therapy results in the removal of the pulp tissue (nerves and blood vessels) from the inside of the tooth, and then seals the space with a filling material. Endodontic therapy enjoys a relatively high degree of success, but because it is a biological procedure, success cannot be guaranteed or warranted. Occasionally, a tooth, which has had endodontic treatment, may require a retreatment, periradicular surgery, or even extraction. During treatment, there is the possibility of instrument separation within the tooth, perforation of tooth structure in gaining access to the canals, and fracturing of the tooth itself. These unlikely events are the hazards of endodontic therapy, and are not dispositive of inadequate treatment by the caregiver.

Following treatment, the endodontically treated tooth **MUST BE RESTORED** to function with a protective restoration, usually a post and crown within **THREE WEEKS**. The patient is advised that the endodontically treated tooth is NOT a final treatment of the tooth, and that the patient should get a protective restoration by his/her dentist as soon as possible to avoid future complications.

Some teeth may not be amenable to endodontic treatment at all. Other treatment choices include no treatment, waiting for more defintive symptoms to develop, or tooth extraction. Risks involved in these choices include but are not limited to pain, swelling, loss of tooth, infection, and spread of infection to other areas.

Complications of endodontic therapy and anesthesia may include swelling, pain, trismus (restricted jaw opening), infection, bleeding, sinus involvement, and numbness of the lip, gum, or tongue, which rarely is protracted, and even more rarely permanent.

The nature of endodontic therapy has been explained to me. I have had the opportunity to have my questions concerning the nature of my treatment answered to my satisfaction by the doctor.

_____	_____
Patient Name (please print)	Date
_____	_____
Patient Signature (Guardian if patient is a minor)	Christopher K. Ross, D.M.D.