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 Phone: _____ Cell: _____ Work: _____

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 the above named 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 Responsible Party | 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 Number: _____

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 describe 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

INFORMED CONSENT FOR GENERAL DENTAL PROCEDURES

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre- and post-treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be Provided

I understand that during my course of treatment, the following care may be provided:

• Examinations • Endodontic Therapy PATIENT INITIALS: _____

2. Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (a severe allergic reaction).

PATIENT INITIALS: _____

3. Changes in Treatment Plan

I understand that it may be necessary to change or add procedures during treatment because of conditions found during the course of treatment that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. PATIENT INITIALS: _____

4. Insurance

I give permission to Westford Endodontic Care to bill my dental insurance provider for the treatment provided, if applicable. PATIENT INITIALS: _____

_____ _____

Signature of patient, parent, guardian or personal representative Date