Endodontics New Patient Intake

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Name: _____ Date of Birth: _____ A.H.C. #: _____

Home Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Emergency Contact Name: _____ Cell phone: _____

If Patient is a minor, name of parent / guardian: _____ Phone (if different from above):_____

Current Dentist: _____

If you were not referred to us by your current dentist, how did you hear about us: ☐ Word of mouth ☐ Lifepath ☐ The Anchor

☐ Facebook ☐ Internet search / Website ☐ Family / Friend ☐ Other_____

Medical Physician: _____ Are you presently being treated by a physician? _____

Are you taking any medications now? _____ If yes, please list: _____

_____

Do you have any allergies (medications/drugs/food): _____ If yes, please list: _____

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma or Hay Fever
- ☐ Blood Disease
- ☐ Bone Disease
- ☐ Cancer - Type: _____
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting Spells
- ☐ Glaucoma
- ☐ Tuberculosis
- ☐ Heart Ailments
- ☐ Heart Murmur
- ☐ Hepatitis A, B, or C
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Immune Disorder
- ☐ Joint Replacement
- ☐ Pacemaker
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Nervous Disorders
- ☐ Osteoporosis
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever or Rheumatic Heart Disease
- ☐ Seizures
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Surgery - When: _____
- ☐ Tumors or Growths
- ☐ Other:

Women: Are you pregnant? _____ ***Please inform our office if you become pregnant prior to or during the course of treatment.***

PRESENT SYMPTOMS:

- ☐ None
- ☐ Heat
- ☐ Cold
- ☐ Sweet
- ☐ Relieved by Cold
- ☐ Apical Palpation
- ☐ Pressure
- ☐ Unstimulated/Spontaneous
- ☐ Swelling
- ☐ Acute
- ☐ Moderate
- ☐ Mild
- ☐ Constant
- ☐ Intermittent
- ☐ Interferes with Sleep
- ☐ Interferes with Eating
- ☐ Needs Pain Medication
- ☐ Is there any relief and what helps? _____

Are you taking any pain medication? _____ If yes, please list: _____

- **To the best of my knowledge all of the preceding answers and information provided are true, complete and accurate.**
- **I grant permission to you and your assignees to telephone me to discuss matters related to this form.**
- **I understand that this information is held in the strictest confidence and it is my responsibility to inform the office of any changes to my medical or dental history.**

_____ _____ _____

Signature *Date* *Printed Name*

CONSENT FOR ENDODONTIC TREATMENT

Endodontic therapy/root canal treatment involves the removal of pulp tissue (nerve) inside the tooth and the sealing of the root canal with a suitable filling material (typically a rubber based material known as gutta percha and sealer consisting of zinc oxide and eugenol). The primary purpose of this procedure is to maintain your tooth by treating the diseased pulp and surrounding tissues, which would otherwise have been lost to extraction.

Although endodontic therapy has a considerably high success rate (over 90%), as with any procedure the results cannot be guaranteed. Long-term prognosis depends on several factors including your immunity and ability to heal, the time at which your definitive restoration was placed, and your ability to maintain good oral hygiene.
This procedure will not prevent future tooth decay, tooth fracture, or gum disease. Occasionally, a tooth that has had root canal treatment may require retreatment, endodontic surgery, or tooth extraction as it is a biological procedure and at times the infection may not heal after the root canal system has been sealed.

Risks of Endodontic Therapy

Although rare, complications may occur during root canal treatment and are typically related to the use of dental instruments when cleaning and shaping the tooth, delivering the local anesthetic, filling the root canal system, or as a result of reactions to anesthetics, chemicals, or medications used during treatment. Complications may include (but are not limited to): swelling, sensitivity, pain, pressure, bleeding, transient or permanent numbness and a tingling sensation in the lip, tongue, cheek, gums, and teeth (occasionally a tooth that has been root canal treated may feel different than the adjacent teeth), changes in occlusion (bite), jaw soreness, muscle cramps and spasms, TMJ difficulty, loosening of teeth, referred pain to the ear, neck, and head, post-treatment discomfort, incomplete healing, and/or infection requiring additional treatment or antibiotics. The specialized instruments used to clean the canal can also separate (break) within the canal and perforations (extra-openings in the canal) can be created which may or may not affect prognosis. Blocked canals may occur which may impede treatment, fractures, chips, or damage can occur to a pre-existing restoration /crown requiring replacement, and tooth and/or root fractures can occur necessitating extraction. If the tooth does not receive a definitive restoration/crown as soon as possible, but no greater than two (2) weeks after endodontic treatment, there is a risk of bacterial leakage, contamination and post-treatment disease necessitating retreatment at patient's own cost. There is also a possibility that persistent apical infection, presence of a cyst/granuloma, or extra-radicular bacteria would prevent periapical healing or resolution of symptoms, thus necessitating an apicoectomy after conventional endodontic treatment.

Alternatives to Endodontic Treatment

Depending on the current diagnosis there may be alternative options to root canal treatment. The most common treatment options include:

• **No treatment.** If no treatment is rendered the current condition of your tooth could worsen and can lead to serious risks including severe pain, swelling, localized infection, loss of tooth and/or adjacent teeth, destruction of surrounding bone, and spread of infection which could be potentially fatal.
• **Extraction**. Removal of this tooth will typically compromise function, aesthetics, and form and is therefore usually replaced by an artificial tooth by means of a fixed bridge, dental implant, removable partial denture, or it can be left alone.

If a crown is present, treatment will require drilling through the crown which may subsequently fracture/chip and require replacement. Should this happen it is due to the way the metals are fabricated in the laboratory and cannot be avoided.

Upon the completion of endodontic treatment, the tooth will require a permanent restoration (crown, filling), which should ideally be placed within 3 weeks. Failure to have the tooth properly restored in a timely manner significantly increases the potential for root canal failure or tooth fracture.

I the undersigned, being the patient, parent or guardian of the above minor patient, consent to undergo whatever endodontic treatment procedures are deemed necessary or advisable, in the opinion of the doctor. I understand that root canal therapy is an attempt to retain a tooth that 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 further understand that the FINAL RESTORATION of the tooth (with a filling, inlay, crown, etc.) will be done by my regular dentist AT AN ADDITIONAL FEE.

I, _____ have had the opportunity to read the information provided to me on this consent form, fully understand the risks and the rationale for endodontic therapy,

treatment alternatives have been discussed with me, and I have been given an opportunity to question the doctor regarding the nature of treatment. As a result, I am now comfortable and willing to move forward with the prescribed treatment.

_____	_____	_____
Signature	*Date*	*Clinic Staff Initial*

OUR APPOINTMENT POLICY

Thank you for allowing us the privilege of being your Dental Health provider. Our practice is dedicated to quality care and is pleased to reserve time exclusively for each patient.

We respect our patients' time and make every effort to remain on schedule. Despite careful scheduling, dental emergencies can cause delays. If your appointment time is affected due to an unforeseen emergency, we will try our best to notify you in advance. We know that your time, like our Doctor's, is valuable and we will make every effort to see you on time and will ensure you are given the same time and attention for your dental health.

Because we reserve time exclusively for you, we ask that you make every effort to keep your reserved appointment time. If you find that you cannot keep your scheduled visit, **we require a minimum of 2 business day's notification**. Advance notice allows our office to see other patients who may have been waiting to see us for needed treatment. We thank you in advance for your consideration. *A charge of $75.00 may apply to your account if sufficient notice is not provided; this charge is at the discretion of your Doctor.*

_____ *initial*

FINANCIAL POLICIES FOR PATIENTS WITH DENTAL INSURANCE

(IMPORTANT: Please read and initial if you request direct billing to your Insurance,
if you wish to pay in full for your dental treatment and be reimbursed by your dental plan, please disregard this section.)

Many of our patients have dental insurance. While your dental insurance policy is an agreement between you and your insurance company, we will be happy to assist you in preparing and sending in the necessary forms. Please remember that no insurance company attempts to cover all dental costs. We cannot render dental treatment on the assumption that our charges will be paid in full by an Insurance Company. Full payment to our office remains your responsibility, regardless of how much your insurance does or does not pay. (Please see the attached information on dental insurance for more information.)

I am aware that Chestermere Station Dentistry direct bills my Insurance Company as a courtesy to me and that in doing so, the dental office accepts no responsibility for any uncovered amounts, amounts over benefit maximums, limitations or plan restrictions, etc. I understand that the dental office collects my dental coverage information as a guideline ONLY to assist me in maximizing my benefits this does not hold them responsible for my dental account. Chestermere Station advises that I make myself very aware of my dental plan, knowing my coverage and that I ask my dental team about any and all procedures I am authorizing. _____ *initial*

Chestermere Station Dentistry advises me to contact my plan administrator or Insurance Company for questions regarding eligible procedures and authorization of treatment. And to make myself aware of all costs involved with my dental care. Chestermere Station advises me to keep track of my yearly maximums, limitations, appointment dates, and accumulated amounts used on my dental benefit plan. _____*initial*

Payment is due at the time of service. I am aware that if the dental office does not receive confirmation from my Insurance for their exact payment— Chestermere Station will estimate my portion only at the time of visit. Any unforeseen balances will then be informed to me by statement. I agree to pay all of these uncovered portions within **10 days** from the date of statement or interest charges of 5% per month may be applied to my account. I agree to pay these interest charges if applied to my overdue account. _____ *initial*

I also understand that any uncovered procedures that may have been done at another Dental office are my responsibility. IMPORTANT: Please be advised that complete oral examinations (new patient exams) & x-rays will be denied by your insurance if you have had this procedure at another dental office within the time limitations on your specific plan. You are responsible for this procedure in our office should this not be an eligible benefit with your coverage. _____ *initial*

I am aware that NSF fees (returned cheques) are $50 for every returned personal cheque. _____ *initial*

ACCOUNTABILITY CONFIRMATION

I, the undersigned, clearly understand all policies of Chestermere Station Dentistry. I understand and agree to pay all fees associated with my dental treatment. With or without dental coverage, I agree it is my responsibility to make myself aware of those fees prior to any dental treatment.

_____	_____	_____
Signature	*Date*	*Printed Name*

DENTAL OFFICE PERSONAL INFORMATION CONSENT

Privacy Act Information

We are committed to protecting the privacy of our patients' personal information and to utilizing all personal information in a responsible and professional manner. This document summarizes some of the personal information that we collect, use and disclose. In addition to the circumstances in this form, we also collect, use and disclose personal information when permitted or required by law.

We collect information from our patients such as names, home addresses, work addresses, home telephone numbers, work telephone numbers and e-mail addresses. (Collectively referred to as "Contact Information".) Contact information is collected and used for the following purposes:

- To open and update patient files
- To invoice patients for dental services, to process credit card payments, or to collect unpaid accounts
- To process claims for payment or reimbursement from third party health benefit providers and insurance companies
- To send reminders to patients concerning the need for further dental examination or treatment
- To send patients informational material about our dental materials
- To follow up with treatment and/or customer services

Contact information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient's behalf.

Financial information may be collected in order to make arrangements for the payment of dental services. We collect information from our patients about their health history, their family health history, physical condition, and dental treatments. (Collectively referred to as "Medical Information".) Patients' Medical Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment.

Patients' Medical Information is disclosed for the following purposes:

- To third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient's behalf
- To other dentists and dental specialists where we are seeking a second opinion and the patient has consented to us obtaining the second opinion
- To other dentists and dental specialists if the patient, with their consent, has been referred by us to the other dentist or dental specialist for treatment
- To other dentists and dental specialists where those dentists have asked us, with the consent of the patient, to provide a second opinion
- To other health care professionals, such as physicians, if the patient, with their consent, has been referred by us to the other health care professional for either a second opinion or treatment

If we are ever considering selling all or part of our dental practice, qualified, potential purchasers may be granted access, as part of the due diligence process, to patient information in order to verify information important to the potential sale. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information.

Dentists are regulated by the Alberta Dental Association and College, which may inspect our records and interview our staff as part of its regulatory activities in the public interest.

_____ _____

Signature *Date*

INSURANCE INFORMATION

Insurance Information *(or you may provide your insurance card for us to copy and keep on file)*

If your plan does not allow to pay the Dentist directly, you are responsible to pay in full for your treatment on the date of service.

Primary Plan - For children, the parent whose birth month comes first in the year is Primary plan

Insurance Company: _____ *Group #:* _____

ID or Certificate #: _____ *Employer/Company Name:* _____

Subscriber/Policy Holder's name: _____ *Subscriber Date of Birth:* _____

Secondary Plan

Insurance Company: _____ *Group #:* _____

ID or Certificate #: _____ *Employer/Company Name:* _____

Subscriber/Policy Holder's name: _____ *Subscriber Date of Birth:* _____

YOUR DENTAL INSURANCE

Canadian Dental Association
L'Association dentaire canadienne

Many patients possess employer-sponsored dental prepayment plans, often referred to as "dental insurance." These plans are not considered insurance in the traditional sense. Instead, these plans cover a portion of the fees for dental services utilizing prepaid benefits, which are traditionally part of your compensation plan. We are not privy to the specifics of each of these plans, and not all dental plans are the same.

Alberta dentists set their own fees for services. The Alberta Dental Association and College has also provided practice management information and courses to dentists, to help them in determining costs and how to set fees. The fees set by dentists are based on a number of factors, including the time and complexity of the services provided, provincial requirements for maintenance and sterilization, the value of that service to the patient, and overhead costs of staff, materials, rent, loans, bank financing, insurance, continuing education, and utilities among others. Fees are not based upon availability of a dental plan, insurance or what coverage is available for specific services.

Your health and well-being is our concern. Our providers make treatment recommendations based upon your individual needs and health requirements. We do not base our treatment plans or recommendations upon the level of insurance available to you. However, it is your responsibility to know what coverage is available to you. You can obtain coverage information directly from your company or organization's plan administrator or insurance carrier before visiting the dentist. If you have concerns regarding your dental plan or insurance coverage, contact your employer's human resources department, union leader or employer for details. It is unlikely that any dental plan would cover every service that you may need.