McKINNEY ENDODONTICS

## Patient Information

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date:_____

Phone (Home): _____ (Work): _____ Ext:_____ Cell Phone:_____

Email Address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

## Health Information

Date of Last Dental Visit: _____ Reason for this visit:_____

**Have you ever had any of the following? Please check those that apply:**

| | | | |
|---|---|---|---|
| ☐ AIDS | ☐ Glaucoma | ☐ Nervous Disorders | ☐ Tumors |
| ☐ Anemia | ☐ Growths | ☐ Pacemaker | ☐ Ulcers |
| ☐ Arthritis | ☐ Hay Fever | ☐ Are you Pregnant | ☐ Venereal Disease |
| ☐ Artificial Joints | ☐ Head Injuries | Due date:_____ | ☐ Codeine Allergy |
| ☐ Asthma | ☐ Heart Disease | ☐ Radiation Treatment | ☐ Penicillin Allergy |
| ☐ Blood Disease | ☐ Heart Murmur | ☐ Respiratory Problems | ☐ Allergies _____ |
| ☐ Cancer | ☐ Hepatitis | ☐ Rheumatic Fever | _____ |
| ☐ Diabetes | ☐ High Blood Pressure | ☐ Rheumatism | OTHER: |
| ☐ Dizziness | ☐ Jaundice | ☐ Sinus Problems | ☐ _____ |
| ☐ Epilepsy | ☐ Kidney Disease | ☐ Stomach Problems | |
| ☐ Excessive Bleeding | ☐ Liver Disease | ☐ Stroke | ☐ _____ |
| ☐ Fainting | ☐ Mental Disorders | ☐ Tuberculosis | |

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____
- Please list ALL medications, vitamins, and supplements you are taking (include Aspirin, herbal supplements, oral contraceptives, etc.) _____
  _____
- Person to contact in case of emergency:_____ Phone:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

X_____ Date: _____
Signature of patient, parent or guardian

### Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

Name of person or office referring you to our practice: _____

## Insurance Information

The following is for: ☐ the patient ☐ the person responsible for payment

**Primary**

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

**Secondary**

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

## (No insurance available) Responsible Party Information

The following is for: ☐ the patient responsible for payment (skip to next section) ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Relationship to patient: _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ Cell Phone: _____

Address: _____
Street Apartment #

_____
City State Zip Code

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

X _____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

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# CONSENT FOR ENDODONTIC CONSULTATION, X-RAYS, DIAGNOSIS, AND/OR TREATMENT

I understand that all procedures and treatments have inherent and potential risks. These risks include, but are not limited to complications resulting from the use of dental instruments, drugs, sedation, medicines, pain killers, anesthetics, and injections. These complications include, but are not limited to: swelling, sensitivity, bleeding, bruising, pain, infection, cold sores, changes in bite; jaw muscle/joint difficulty, referred pain to ear, neck and head, numbness and tingling sensation in areas of the mouth which are transient, but on rare occasions may be permanent; loosening or damage of teeth, crowns, or bridges; allergic reactions' delayed healing; sinus problems; the possibility of instruments broken within the root canals, extra openings of the crown or root of the tooth, filling material extending past the end of the roots.

There may be periods of discomfort during or following treatment. Many factors contribute to the success or failure of root canal therapy, which cannot be determined in advance. Therefore, in some cases treatment may have to be changed, discontinued before it is completed, or may fail following treatment. Some of these factors include, but are not limited to: the shape and location of the canal anatomy, blocked canals due to filling or prior treatment, natural calcification, broken instruments, periodontal (gum) involvement, or an undetected or after the fact split (crack) in the tooth; also, my resistance to infection, my failure to keep scheduled appointments, my failure to obtain a permanent restoration following treatment.

I further understand that prescribed medication and drugs may cause drowsiness, nausea, vomiting, and lack of awareness and coordination, which may be exaggerated by the use of alcohol, tranquilizers, sedatives, or other drugs. The use of antibiotic drugs may have an adverse action on the effect of birth control pills.

I have been given the opportunity to have my questions answered. I understand that I will always have the option to discontinue treatment or elect extraction as opposed to accepting the continuation of the recommended treatment. I understand that root canal treatment is an attempt to salvage 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 re-treatment, surgery, or even extraction.

I have been truthful and accurate in the health history and personal information I provided. If there is a change in health or in medications taken, I will inform the doctor at my next appointment. I also accept these procedures outlined above and understand the need for such treatment as well as possible complications and the fees involved.

Signature: X _____ Date:_____
(Parent, Guardian, or Agent if patient is under age 18)


Matthew Lloyd, DMD, MSD  Paul D. Clark, DDS, MSD

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement, however, treatment may not be performed.

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

_____
Please Print Name

X _____
Signature

_____
Date

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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:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)