PATIENT INFORMATION (Please Print)

Title: _____ First Name: _____ MI: ____ Last Name: _____

Birthdate: _____ Soc. Sec.: _____ Gender: ◯ Male ◯ Female

Address: _____ Apt./Suite: _____

City: _____ State: _____ Zip Code: _____

Phones: Home: _____ Work: _____ Ext: _____

Mobile: ( ) - _____ Fax: _____ Email: _____

Employer: _____ Phone: ( ) - _____ Occupation: _____

Referred By: _____ General Dentist: _____

Have you been seen in this practice before today? ◯ Yes ◯ No

PERSON RESPONSIBLE FOR ACCOUNT (if other than patient)

Title: _____ First Name: _____ MI: ____ Last Name: _____

Relationship to Patient: ☐ patient ☐ spouse ☐ child ☐ other - please specify _____ Soc. Sec.: _____

Address: _____ Apt./Suite: _____

City: _____ State: _____ Zip Code: _____

Phones: Home: _____ Work: _____ Ext: _____

Mobile: ( ) - _____ Fax: _____ Email: _____

Employer: _____ Phone: ( ) - _____ Occupation: _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Ins. Co. _____

Group #: _____ Phone: _____

Employer: _____

Employee (if other than patient)

Name: _____

Birthdate: _____ Soc. Sec.: _____

Subscriber #: _____ Sex: ◯ Male ◯ Female

Secondary Insurance

Ins. Co. _____

Group #: _____ Phone: _____

Employer: _____

Employee (if other than patient)

Name: _____

Birthdate: _____ Soc. Sec.: _____

Subscriber #: _____ Sex: ◉ Male ◯ Female

In case of emergency contact: _____

Relationship: _____

Phone: _____

_____ _____ _____ _____

Signature (parent or guardian if patient is a minor) Date Signature of authorized representative of Worcester Endodontics Date

WORCESTER ENDODONTICS
PATIENT MEDICAL HISTORY FORM

We take our patients health very seriously. Answer questions to the best of your knowledge.

PATIENT NAME: ***NO ABBREVIATIONS ON EXPLANATIONS PLEASE!!!!!!***

PERSONAL MEDICAL HISTORY: please indicate whether you have had any of the following medical problems:

	Yes	No	Specify Type
1. Heart Disease:	_____	_____	_____
2. High Blood Pressure:	_____	_____	_____
3. Diabetes:	_____	_____	_____
4. Thyroid Disease	_____	_____	_____
5. Cancer:	_____	_____	_____

6. SURGICAL HISTORY: please list all prior operations and dates: ***NO ABBREVIATIONS***

_____

_____

7. MEDICATIONS: prescription and non-prescription medicines, aspirin, blood thinners, vitamins, herbal meds, etc: _____

_____

_____

8. ALLERGIES OR REACTIONS TO MEDICINES/FOODS/OTHER AGENTS:

_____

_____

9. Has there been any change in your general health within the past year? (explain)

_____

10. Have you ever required a blood transfusion? _____

11. Have you ever had abnormal bleeding with previous extractions, surgery or trauma?

_____

12. Have you ever had radiation/chemotherapy, growth or other condition? _____

_____

13. Have you ever tested positively for HIV, AIDS or HEPATITIS? _____

If so list treating doctor: _____

_____

14. Do you have a heart murmur, artificial joints, organ transplant? _____

15. Are you required to take antibiotics prior to dental treatment for any condition #14?

_____

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

_____

17. Have you received therapy for Alcoholism or Drug Addiction? _____

18. Do you wish to speak to the doctor privately about anything? _____

19. Do you Smoke: Yes _____ **No** _____

WOMEN:	**Yes**	**No**		**Yes**	**No**
Are you pregnant:	_____	_____	**Nursing:**	_____	_____
On birth control pills:	_____	_____			

SIGNATURE PATIENT/GUARDIAN: _____ **DATE:** _____

WORCESTER ENDODONTICS
CONSENT FOR TREATMENT

Please review the following consent form. You will be required to sign this form prior to the initiation of treatment. Your signature does not commit you to any treatment. Occasionally, medication will be prescribed by the doctor. Medications prescribed for discomfort and/or sedation may cause drowsiness, which can be increased by the use of alcohol or other drugs. We advise that you do not operate a motor vehicle or any hazardous equipment while taking such medications. In addition, such medications may cause allergic reactions, such as hives or intestinal discomfort. If any of these problems occur, please contact the office immediately. I understand the root canal therapy is a procedure that retains a tooth which may otherwise require extraction. As a specialty practice, this office performs only endodontic therapy and associated treatment including surgery and implants. Although root canal therapy has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require revision, surgery or even extraction. Following treatment, the tooth may be brittle and subject to fracture. A restoration (filling), crown, and/or post and core build-up will be necessary to restore the tooth, and your general dentist will perform these procedures. During endodontic treatment, there is the possibility of instrumentation separation within the canals, perforations (extra openings), damage to bridges, existing fillings, crowns or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when the tooth may not be amendable to endodontic treatment at all. There is a slight risk of paresthesia with surgical and non-surgical procedures. Other treatment options include-no treatment, a waiting period for more definitive symptoms to develop, or tooth extraction. Risks involved in those choices might include, but are not limited to pain, infection, swelling, loss of teeth and infection to other areas. I give Worcester Endodontics my permission to record, tape and or take digital x-rays and photographs for purposes of completing my medical record. All of my questions have been addressed to the doctor and trained staff and I fully understand the above statements within this consent form and I give my consent for treatment.

ALL MEDICAL RECORDS WILL BE KEPT STRICTLY CONFIDENTIAL

Patient signature: _____
(if patient is under the age of 18, the signature of a parent or guardian is required.)

Date: _____

Worcester Endodontics care

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: CONSENT FROM PATIENT

NAME: _____

ADDRESS: _____

TELEPHONE: _____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment and activities and healthcare operations.

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations of the uses and disclosures we may make of your protected health information, and of other important matters about your health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes which may apply to any of your protected health information which we maintain.

You may obtain a copy of our Notice of Privacy Practices including any revisions, at any time by contacting Worcester Endodontics, the office of Jay Marlin, DMD.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the office manager at Worcester Endodontics. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE:

I,_____, have had the opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

SIGNATURE_____DATE_____