# Root Canal Specialists

Dr. Amy Amaro Dr. Christopher Lento

**PERSONAL INFORMATION** Today's Date ____________

(Mr. / Mrs. / Ms. / Dr.) Name ______________________________ Nickname ______________

Address ________________________ City __________________ ST ______ Zip ______

Home Phone ______________ Cell Phone ______________ Soc Sec # ______________

Birth Date __________ Sex _____ Single ___ Married ___ Divorced ___ Widowed ___ Separated ___

Employer ______________________________ Occupation ____________________

Address ________________________ City __________________ ST ______ Zip ______

Work Phone ______________ Ext ________ How long employed there ______________

In the event of an emergency, who should we contact?
Name ________________________ Relationship ____________ Phone ______________

Who referred you to our office? ________________________________________

## HEALTH HISTORY

Your overall health or medications that you may be taking could have an important impact on the dental care you will be receiving. Thank you for answering the following questions.

Physician's Name ________________ City/Town ____________ Phone ______________

Have you ever had any of the following? (Check boxes that apply)

____ Heart Problem
____ Artificial Heart Valves
____ Rheumatic Fever
____ High Blood Pressure
____ Low Blood Pressure
____ Circulatory Problems
____ Artificial Joints
____ Blood Diseases
____ Hemophilia
____ Recent Weight Loss
____ Cancer (area: ________)
____ Radiation Treatment
____ Chronic Diarrhea

____ Asthma
____ Respiratory Disease
____ Diabetes
____ Special Diet
____ Epilepsy
____ Migraines/Headaches
____ Liver Disease
____ Hepatitis/Jaundice
____ Psychiatric Care
____ Nervous Problems
____ Thyroid Problem
____ Swollen Neck Glands
____ Arthritis

____ Latex Allergies
____ Allergies/Sinus Problem
____ Allergies to Medicines
____ Allergies to Anesthetics
____ Are you taking Aspirin?
____ "AIDS" or other Immunosuppressive Disorder
____ Stroke
____ Ulcer
____ Venereal Disease
____ Chemical Dependency
____ Currently Pregnant
____ Nursing Mother

Please list any medications you are currently taking: ______________________________

________________________________________________________________

Do you have any drug allergies or have you ever had an adverse reaction to medication:
If so, please describe them ________________________________________
Have you ever responded adversely to medical or dental treatment? ____________________
Are you under the care of a physician? If yes, what condition? ____________________
Is there any other medical condition we should know about? ____________________

Interviewing Dr.'s Signature ____________________ Date: __________

PLEASE CONTINUE INFORMATION ON BACK OF THIS PAGE .......

## FINANCIAL POLICY INFORMATION

**Patients without Insurance Assistance: Payment in full is due at the time of your appointment.** Your payment can be made by cash, personal check or credit card. Please see the receptionist for details or questions.

**Patients with Insurance Assistance:** Your insurance may not cover all of your treatment; therefore we require your "estimated" co-payment at the time of your appointment. In order to utilize your insurance in our office, we will need to verify your coverage prior to any treatment. **We cannot guarantee the amount paid by your insurance.** As a courtesy to you, our patient, we will submit to your insurance company for you. We may not be a direct provider for your insurance company. Please understand that your insurance policy is a contract between you and your insurance company. **The payment for your treatment is your responsibility.**

**I have read and understand the financial information:** ______________________________ **Date**
**(Signature of responsible party, patient or guardian)**

## INSURANCE INFORMATION:

| **Primary Dental Insurance** | **Secondary Dental Insurance** |
|---|---|
| Name of Insured ____________________ | Name of Insured ____________________ |
| Insured's birth date ________________ | Insured's birth date ________________ |
| Insured's Soc Sec # ________________ | Insured's Soc Sec # ________________ |
| Insured's Employer ________________ | Insured's Employer ________________ |
| Insured's Occupation _______________ | Insured's Occupation _______________ |
| Relationship to patient _____________ | Relationship to patient _____________ |
| Insurance Company ________________ | Insurance Company ________________ |
| Insurance Co. Address ______________ | Insurance Co. Address ______________ |
| ____________________________ | ____________________________ |
| Group # ________________________ | Group # ________________________ |
| Subscriber or ID # _________________ | Subscriber or ID # _________________ |

## Authorization and Release

I authorize **Root Canal Specialists, P.C.** to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my dependent to third party payers and /or other health practitioners. I authorize and request my insurance company to pay directly to **Root Canal Specialists, P.C.**, any insurance benefits otherwise payable to me. I understand that my dental insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

**Signature** ______________________________ **Date** __________
**(Signature of responsible party, patient or guardian)**

The questions on this form have been accurately answered to the best of my knowledge. The information obtained will be utilized in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold my dentist or any other member of his/her staff responsible for any errors and/or omissions that I may have made in completing this form.

**Signature** ______________________________ **Date** __________
**(Signature of responsible party, patient or guardian)**

130 New London Tpke., Suite 4
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F. 860-889-9714

rootcanalspec@cs.com
www.endodonticsct.com

## Pre-Treatment Root Canal Instructions

1. You have been referred to our office for root canal treatment because your general dentist knows that we have expertise in root canal treatment, which allows us to handle your care in an efficient and predictable manner. This minimizes pain and discomfort for you and maximizes a successful outcome. Your care in our office is a trust we do not take lightly. Hopefully, you will notice that the most up to date infection control protocols and advanced dental equipment is used to treat you. Please see our brochures about root canal treatment published by the American Association of Endodontists located in our reception area.

2. We are concerned about any medical problems which may complicate treatment so please discuss these concerns with the doctor.

3. The benefit of the root canal procedure is to treat your diseased oral tissues. Left untreated, your condition may worsen and result in swelling, pain and infection which could make you physically ill. Eventually you could lose the involved tooth. Alternate methods of treatment other than the root canal treatment would include extraction or no treatment at all.

4. Several x-ray films will be needed to be taken during the treatment. The total number is usually between 3 to 6 individual films. We use digital x-rays and a lead apron to protect you from scatter radiation. Any residual radiation exposure is quite minimal. However, if you suspect that you are pregnant, or have concerns about the x-rays, please discuss them with the doctor.

5. Root canal treatment usually requires one or two appointments which are approximately one to one and half hours in length. Occasionally your treatment will require additional visits or lengthier appointments.

6. Our office does not always place the permanent filling in your tooth. After your root canal treatment is competed, you will be informed if the filling we placed is temporary or permanent. If a **temporary** filling is placed, it is **your responsibility to go back to your general dentist to have the permanent restoration done.**

7. We have a very high success rate for root canal treatment in our office. However, success cannot be guaranteed, since every tooth is different and every individual unique. Occasionally, routine root canal therapy is not adequate to solve your dental problem and additional treatment or surgery may be needed to correct the problem.

8. Although unlikely, the treatment subjects you to certain risks including but not limited to the following: post operative discomfort and infection which may require additional treatment, weakening of the tooth and possible loss of the tooth despite our best efforts. We do every thing possible to minimize risks and we have saved many teeth through root canal treatment!

**Please be aware that your scheduled treatment appointment is important to you and to us. If you fail to show up for your scheduled appointment or cancel with less than 24 hour notice we may be forced to terminate our doctor patient relationship with you. Please don't let this happen.**

Please sign that you have read this information: ______________________ Date: __________

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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

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

______________________________________________
Please Print Name

______________________________________________
Signature

______________________________________________
Date

**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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

______________________________________________

______________________________________________

______________________________________________