Westerville ENDODONTICS

Meticulous endodontic care from gentle, experienced hands

Welcome to our office. Please fill out these forms completely. If you have any questions, please ask us. We want to make your visit as easy as possible.

PERSONAL INFORMATION

Patient's Name: ____________________

Today's date: ____________________ Patient's Date of Birth: ____________________

HOW CAN WE REACH YOU?

Home telephone: (__________)____________________ Work telephone: (__________)____________________

Beeper or Cellular phone: (__________)____________________

Where and when is the best time to reach you?____________________

In the event of an emergency, is there a relative, friend or neighbor that we could contact?

Name: ____________________

Relationship: ____________________

Home telephone: (__________)____________________ Work telephone: (__________)____________________

MEDICAL HISTORY – Will be kept confidential

Do you have a personal physician? Yes _____ No _____ Physician's name: ____________________

Date of last visit:____________________ Your current physical health is: Good _____ Fair _____ Poor _____

Do you have a medical condition that requires you to take antibiotics prior to dental appointments? Yes _____ No _____

Do you or have you had any of the following diseases or problems?:

PLEASE CHECK YES OR NO			MEDICATION TAKEN FOR PROBLEM
Heart Murmur or mitral valve prolapse	Yes _____	No _____	____________________
Rheumatic fever or rheumatic heart disease	Yes _____	No _____	____________________
High blood pressure	Yes _____	No _____	____________________
Chest pain/Angina	Yes _____	No _____	____________________
Heart attack/coronary artery disease	Yes _____	No _____	____________________
Pacemaker	Yes _____	No _____	____________________
Hemophilia/Abnormal bleeding	Yes _____	No _____	____________________
Asthma/emphysema	Yes _____	No _____	____________________
Shortness of breath	Yes _____	No _____	____________________
HIV+/AIDS	Yes _____	No _____	____________________
Tuberculosis	Yes _____	No _____	____________________
Sinus problems	Yes _____	No _____	____________________
Do you smoke or use tobacco in any form?	Yes _____	No _____	____________________
Stroke	Yes _____	No _____	____________________
Kidney problem	Yes _____	No _____	____________________

Vicki M. Houck, DDS, MS
DDS: University of North Carolina at Chapel Hill, NC
MS: Endodontics, Ohio State University, Columbus, OH

Saadia Bukhari, DDS, MS
DDS: Ohio State College of Dentistry, Columbus, OH
MS: Endodontics, Ohio State University, Columbus, OH

Advanced, clinically excellent root canal therapy & endodontics…

- Fast, effective pain relief
- Specialized methods for gentle care
- Highly trained & experienced endodontic specialists
- Complete capabilities for optimal patient outcomes
- State-of-the-art knowledge, techniques & equipment
- Thorough evaluations for the most appropriate care
- Meticulous attention to detail
- Accessible, available & responsive

Personalized, caring & convenient…

- Individualized attention & treatment
- Compassionate, dedicated doctors & staff
- Conveniently located just off 270 North
- Open 5 days per week
- Most emergencies seen the same day
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PLEASE CHECK YES OR NO — *MEDICATION TAKEN FOR PROBLEM*

Condition	Yes	No	Medication taken for problem
Seizure disorder (epilepsy/convulsions)	Yes _____	No _____	________________________________
Severe headaches	Yes _____	No _____	________________________________
Diabetes	Yes _____	No _____	________________________________
Hepatitis or other liver disease	Yes _____	No _____	________________________________
Cancer	Yes _____	No _____	________________________________
Ulcers or stomach problems	Yes _____	No _____	________________________________
Joint replacements	Yes _____	No _____	________________________________
Psychiatric problems	Yes _____	No _____	________________________________
Drug/Alcohol abuse	Yes _____	No _____	________________________________
Other: ____________________			________________________________

Comments: ____

____

____

____

____

PLEASE CHECK YES OR NO

Are you allergic to the following?:

Allergen	Yes	No	Allergen	Yes	No
Penicillin	Yes _____	No _____	Aspirin	Yes _____	No _____
Household bleach	Yes _____	No _____	Latex	Yes _____	No _____
Dental Anesthetics	Yes _____	No _____	Codeine	Yes _____	No _____

Are you allergic to any drugs: Yes _____ No _____ If yes, please list:_____________________________

____

____

FOR WOMEN:

Are you pregnant? Yes _____ No _____ Week Number: ______________________________

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DENTAL HISTORY

Why have you come to the dentist today? ______________________________

Are you in pain? Yes _____ No _____ If yes, how long have you been in pain? ______________________________

Is your tooth sensitive to hot and cold? Yes _____ No _____ If yes, how long does pain continue? ______________________

Does hot or cold make the pain go away or ease up? Yes _____ No _____

Do you know for sure which tooth is hurting you? Yes _____ No _____

Does the tooth hurt when you bite down on it? Yes _____ No _____

Do you experience spontaneous pain not related to eating, or hot or cold foods or liquids? Yes _____ No _____

Does the pain wake you up at night? Yes _____ No _____ If yes, please explain:______________________________

____

Are you under any unusual stress at home or work? Yes _____ No _____ If yes, please explain:______________________

____

Are you anxious about your dental visit today? Yes _____ No _____

The approximate date of your last dental visit: ______________________________

Have you ever experienced TMJ problems? Yes _____ No _____

Do you grind your teeth? Yes _____ No _____

Your current dental health is: Good _____ Fair _____ Poor _____

AGREEMENT AND INFORMED CONSENT

The information I have given today is correct to the best of my knowledge. I understand that this information will be kept in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I consent to the necessary diagnostic procedures (including x-rays) to determine if root canal therapy is needed. If root canal therapy is indicated, I will be informed of this and be given the opportunity to decide whether or not I wish to be treated.

I understand that a root canal treatment is a procedure to retain a tooth that otherwise may require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Occasionally a tooth which has had a root canal treatment may require retreatment, surgery, or even extraction.

I also understand that only the root canal therapy is to be performed at this office. The permanent (outside) restoration (filling, onlay, crown, etc) will be done by my regular (general/family) dentist.

I also acknowledge full responsibility for the payment of these services and agree to pay for them in full, in accordance with the current office policy, unless other specific arrangements are made with the office manager before treatment. I understand that my dental insurance carrier may pay less than the actual bill for these services.

I authorize my insurance carrier to issue the dental benefits of my plan directly to this office. I also authorize release of any information to process dental insurance.

Signature: ______________________________ ***Date:*** ______________________

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PERSONAL INFORMATION

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Patient Name: ______________________
Home Telephone: ______________________
Work Telephone: ______________________
Cellular Phone: ______________________
Home Address: ______________________
City: ______________________
State/zip: ______________________
Birth date: ______________________
Male: __________ *Female:* __________
Social Security: ______-______-______
Billing Address, If Different: ______________________
____
Patient's Employer: ______________________
Person Responsible For This Account: ______________________
____
Referred By: ______________________

DENTAL INSURANCE

Do You Have Insurance Through Your Employer? Yes__ No__
If Yes, Please Provide The Following Information:
Employer's Name: ______________________
Dental Insurance Co Name/address: ______________________
____
____
____
Group Number: ______________________
Insurance Company Phone Number: ______________________

Do You Have Other Dental Coverage?
Coverage Through: Spouse: __________ *Parent:* __________
Insured's Name: ______________________
Employer's Name: ______________________
Their Social Security Number: ______-______-______
Their Date Of Birth: ______________________
Insurance Co.: ______________________
Group Number: ______________________
Insurance Telephone Number: ______________________

If you have dental insurance we are willing to work with you to see that you get the maximum benefits from your policy. We want to share with you information that will clarify the way dental insurance works.

It is important that you understand that your insurance policy is a contract between you, your employer and the insurance company. It is not an agreement between this office, your employer or the insurance company.

Your employer and the insurance company negotiate the amount and type of coverage they will provide. Policies differ from insurance company to company, and may vary within the same company, depending on the plan selected. Our office is not involved in this negotiation.

Most dental insurance companies cover a certain percentage of the fee for a root canal, but there are companies that do not cover the procedure at all. Most policies have a yearly deductible and a maximum limit per family member. It is important to find out what portion of the treatment fee your particular policy will cover before we begin treatment. We can assist you with this.

If you are dissatisfied with the amount of coverage or the type of coverage your policy provides, you need to voice your complaint to your employer in hopes that the next time coverage is negotiated you can receive better coverage.

FINANCIAL AGREEMENT

I acknowledge and accept full responsibility for the payment of services provided and agree to pay for them in full, in accordance with the current office policy, unless specific payment arrangements are made with the office manager. I also understand that insurance is submitted as a courtesy to me. In the event my insurance carrier pays less than the total fee charged for services provided, I understand that I am responsible for the remaining unpaid balance. Upon billing, I agree to pay finance charges on all balances due at a rate of eighteen percent (18%) after said balances have been past due.

I authorize the release of any information required for the processing of dental claims. I authorize my insurance carrier to issue benefit payment directly to this office.

SIGNATURE: ______________________ ***DATE:*** ______________________

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