MILLER
ENDODONTICS PA

Medical History Form

Patient Name (please print):_____DOB:_____
Social Security #:_____ (Parent or Guardian if Applicable): _____
Mailing Address:_____City_____State____Zip_____
Phone:_____ ____ Alt Phone:_____ __ May We Text Appointment Reminders? Yes or No
Email Address:_____ Referring General Dentist:_____
Emergency Contact Name, Phone # & Relationship:_____
Parent/Gaurdian (if applicable) DOB:_____ Social Security #_____

Health problems that you may have or medications that you take could have an important interrelationship with dentistry. Please answer all of the following:

Allergies:

Aspirin ____ Codeine ____ Metal ____ Local Anesthetics ____ Sulfa____ Pain Medications_____
Penicillin ____ Bleach ____ Latex ____ List any other allergies:_____

Please Circle "Yes" or "No" to all that apply, if Yes Explain:

Are you currently under a physician's care? Yes No _____
Have you ever been hospitalized or had major operation? Yes No _____
Have you ever had serious head or neck injury? Yes No _____
Are you taking any medications? (Please List) Yes No _____
Have you ever taken **Fosamax, Boniva, Actonel or other bisphosphonates**? (For Osteoporosis) Yes No _____

Do you have any of the following? Please Place X beside all that apply:

____ AIDS/HIV Positive
____ Alzheimer's disease
____ Anaphylaxis
____ Anemia
____ Arthritis/Gout
____ Artificial Heart Valve
____ Artificial Joint
____ Asthma
____ Blood Disease
____ Blood Transfusion
____ Cancer
____ Chemotherapy/Radiation
____ Chest Pains
____ Cold Sores/Fever Blister
____ Congenital Heart Disease
____ Cortisone Meds
____ Diabetes
____ Drug Addiction
____ Emphysema
____ Epilepsy/Seizures
____ Fainting
____ Fibromyalgia
____ Genital Herpes
____ Glaucoma
____ Heart Attack/Failure
____ Heart Murmur
____ Heart Pace Maker
____ Heart Trouble
____ Hemophilia
____ Hepatitis A B or C
____ Herpes
____ High Blood Pressure
____ Hives or Rash
____ Hypoglycemia
____ Irregular Heartbeat
____ Kidney Problems
____ Leukemia
____ Liver Disease
____ Lung Disease
____ MRSA
____ Mitral Valve Prolapse
____ Psychiatric Care
____ Renal Dialysis
____ Stroke
____ Thyroid Disease
____ Tuberculosis
____ Tumors or Growths
____ Ulcers
____ Venereal Disease
____ Yellow Jaundice

WOMEN:
____Pregnant
____ Planning Pregnancy
____ Nursing

Do you prefer Nitrous Oxide(Laughing Gas) for your dental visits?
Please Circle: YES NO
(Not covered by Ins. $100 fee)

Have you ever had ANY serious illness not listed above? Yes No If Yes: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Miller Endodontics of any changes in medical status.

Signature of Patient or Parent/Guardian:_____ Date:_____

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CONSENT FOR ENDODONTIC (Root Canal) THERAPY

1. The purpose of root canal therapy is to retain a tooth that would otherwise require extraction.

2. Treatment will require the use of local anesthetics, a series of diagnostic radiographs (x-rays), and may require multiple visits/appointments. ***PLEASE NOTE**: Dr. Miller will not be responsible for complications resulting from incomplete treatment if patient fails to have treatment completed within 2 months of treatment start date.

3. In most cases, there is only mild discomfort after treatment this is usually controlled with Tylenol, Ibuprofen or other prescribed medications.

4. Endodontic treatment has a high degree of success, but as with any medical or dental treatment, **there is no guarantee of success or outcome.** Occasionally, a tooth which has had root canal therapy may require retreatment, surgery, or even extraction.

5. Accurate and complete disclosure of medical history and information is necessary for proper diagnosis, and to help prevent unnecessary complications during your treatment.

6. **The most common complications with root canal therapy include but are not limited to:**

   A. Continued infection requiring endodontic surgery or extraction of the tooth.

   B. Calcified (narrowed) canals or canals blocked by separated instruments requiring endodontic (root canal) surgery or extraction of the tooth.

   C. Pain, requiring the use of medications.

   D. Side effects and possible reactions to medications.

   E. Fracture of the root or crown of the tooth during or after treatment. It is recommended that all posterior (back) teeth be crowned after root canal treatment. If your tooth already has a crown, there is a chance it will need to be replaced, due to decay or loss of structural support. Also, porcelain crowns are subject to breakage.

   F. Tenderness of the tooth following treatment, due to possible complications with root canal treatment, gum disease, physical stress from chewing, or the degree of healing your body exhibits.

7. Other treatment choices include: No treatment, waiting for more definite development of symptoms, or tooth extraction. **Risks involved with these choices might include pain, infection, swelling, loss of teeth and possible infection to other areas.**

8. If you have any questions, please ask prior to proceeding with treatment.

"I have read and understand the above information, and understand the possible risks involved, and hereby consent to treatment."

Patient signature Date Witness (Office Staff) Date

MILLER

ENDODONTICS PA

I request and authorize my dental insurance company to pay Miller Endodontics directly all insurance benefits for services rendered. I authorize the use of the signature on this page on all insurance submissions. I understand that my insurance gives an ESTIMATE and does not guarantee payment. Miller Endodontics is filling my insurance as a courtesy and I am responsible for ALL unpaid balances relative to my account.

X_____

Patient Signature-Insurance Assignment

I have reviewed and consent to the "Financial Agreement", including the account payment and collection policies of Miller Endodontics, PA., as well as the use of third party collection agencies for delinquent accounts.

X_____

Patient Signature- Financial Agreement

A copy of Miller Endodontics, PA "Notice of Privacy Practices" has been made available for me to review and I authorize the use of my health information as described in that notice.

X_____ Date_____

Permission given to release information to: (List Names):

_____

_____