**For Tooth #:** ☐

# CONSENT FORM

**Please review the following consent form. You will be required to sign it prior to an endodontic evaluation and/or endodontic treatment; however, it does not commit you to treatment.**

This is my consent to the endodontic procedures indicated and any other procedures deemed necessary or advisable in conjunction with the planned endodontic treatment performed by Dr. Aimar or Dr. Bernie. I agree to the use of local anesthesia, depending upon the judgment of the endodontist. I understand the endodontist will consult with me prior to dispensing any medication for discomfort or anxiety. Some risks involved in endodontic therapy and local anesthesia may include, but not limited to, chronic pain, infection, swelling, trismus (muscle spasm), chronic numbness (tingling of the lip or gum), sinus injury or bleeding. I understand that it is my responsibility to report any of these symptoms or untoward reaction to the endodontist immediately.

## ☐ CONSENT FOR ENDODONTIC TREATMENT

I understand that endodontics is a specialty of dentistry that enables patients to retain teeth that would otherwise be extracted. As a specialty practice, this office performs only endodontic therapy and associated surgical procedures. Although endodontics has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth that has had endodontics may require retreatment, surgery, or even extraction. Following treatment, the tooth may be susceptible to fracture. A restoration (filling), crown, and/or post and core will be required to restore the tooth to function. You may be required to return to your dentist for this restoration. Complications during treatment may include instrument separation within the root canals, perforations (extra openings), damage to prostheses (such as bridges, crowns, porcelain veneers or existing fillings), missed canals, loss of tooth structure in gaining access to canals and fractured teeth. A minor surgical procedure may also be required when the tooth is not amenable to routine endodontics. You should also be aware of alternatives to immediate endodontic therapy, which sometimes include no treatment, waiting for more definitive symptoms to develop, or tooth extraction.

## ☐ CONSENT FOR ENDODONTIC RETREATMENT

I understand that endodontic retreatment, although frequently successful in correcting a failed root canal, is very complex and unpredictable. It is technically more difficult than the original endodontic procedure, and occasionally unforeseeable problems do arise during retreatment that requires re-evaluation of alternatives. There may be the need for endodontic surgery or possible extraction. Following treatment, the tooth may be brittle and subject to fracture. A restoration (filling), crown, and/or post and core will be necessary to restore the tooth to function. You may be required to return to your dentist for this restoration. During treatment there is the possibility of instrument separation within the root canals, perforations (extra openings), damage to bridges, crowns, porcelain veneers or existing fillings, missed canals, loss of tooth structure in gaining access to canals and fractured teeth. Other treatment choices include no treatment, waiting 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.

**INDICATED PROCEDURE:** _____

DATE: _____ DOCTOR: _____

SIGNATURE: _____

Patient's Legal Name: _____ Age: _____

Name you prefer: _____ Email- _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (____) _____-_____ Work: (____) _____-_____ Cell: (____) _____-_____

Employer's Name: _____ Job Title: _____

SSN # _____-_____-_____ Date of Birth: _____/_____/_____

Spouse's name: _____ Spouse's Date of Birth: _____ / _____ / _____

Who is your referring Dentist? _____ Phone: _____-_____

Medical Physician: _____ Phone: _____-_____

KAISER #_____ Preferred Pharmacy: _____ Phone: _____-_____-_____

***Is this visit due to an accident? YES / NO If so, when?*** _____

## DO YOU CURRENTLY HAVE OR HAD ANY OF THE FOLLOWING?

## *Circle each YES or NO*

*Y or N – Any Heart Problems*
Y or N – High Blood Pressure
Y or N – Low Blood Pressure
Y or N – Malignancies
Y or N – Excessive Bleeding
Y or N – Circulatory Problems
Y or N – Oral Herpes
Y or N – Osteoporosis
Y or N – LATEX ALLERGY

*Y or N – Sinus Problems*
Y or N – Heart Murmur
Y or N – Tuberculosis
Y or N – Diabetes
Y or N – Hepatitis A, B, C
Y or N – Arthritis
Y or N – Radiation Treatment
Y or N – Do you take aspirin daily

*Y or N – AIDS/ HIV*
Y or N – Ulcers
Y or N – Stroke
Y or N – Asthma
Y or N – TMJ
Y or N – Anemia
Y or N – Rheumatic Fever

Y or N – Has your Medical Physician recommended that you pre-medicate with Antibiotics prior to receiving dental treatment each time you visit the Dentist?

Are you allergic to any medications? Please list: _____

If female, do you take birth control pills? Y or N Are you pregnant? Y or N

Are you nursing? Y or N

Have you had heart surgery? Y or N If yes, when? _____

Do you have any prosthesis (plastic, metal bone/joint replacement) Y or N

If YES, please explain: _____

Are there any other medical or dental conditions that could affect treatment? Y or N

If YES, please explain: _____

What medications are you currently taking? _____

_____.

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED EVERY QUESTION COMPLETELY AND ACCURATELY. I WILL INFORM MY DENTIST OF ANY CHANGE IN MY HEALTH OR MEDICATION PRIOR TO TREATMENT.

SIGNATURE OF PATIENT/PARENT: _____ DATE: _____

HEALTH HISTORY UPDATED: _____ DATE: _____

DENTAL INSURANCE INFORMATION

Name of Dental Insurance Carrier: _____

Phone #: _____ Group Plan # _____

Subscriber Name: _____ Social Security # ____-____-_____

DOB: ____/____/____ Relationship to Patient _____ Employer _____

SECONDARY CARRIER

Name of Dental Insurance Carrier: _____

Phone #: _____ Group Plan # _____

Subscriber Name: _____ Social Security # ____-____-_____

DOB: ____/____/____ Relationship to Patient _____ Employer _____

We may use and disclose your health information to your referring dentist, a physician or other healthcare provider providing treatment to you. We may use and disclose your health information to obtain payment for services we provide to you.

I authorize the release of information on behalf of myself and/or my dependent. I authorize and request my insurance company to pay directly to the dentist any insurance benefits otherwise payable to me. I understand that the ***ESTIMATE*** presented to me is ***ONLY AN ESTIMATE*** and ***NOT A GUARANTEE*** of payment by my insurance carrier.
I understand I am responsible for all services rendered.
FEES WILL BE QUOTED ONCE TREATMENT IS RENDERED

*I ACKNOWLEDGE RECEIPT/REVIEW* OF THE NOTICE OF PRIVACY PRACTICES
(A copy can be given upon request.)

SIGNATURE: _____ DATE: _____

I request that my treatment and financial information be shared with: _____
PRINT NAME

## FINANCIAL POLICY

We collect payment for services upon completion of treatment.
If you do not have insurance, we will collect payment in full.
If you have insurance, we will estimate your co-payment and collect this amount.
We accept cash, check, credit/debit cards including Visa, Mastercard and American Express. We are Care Credit Providers.

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**Please read the following if you have dental insurance**

-If you provide complete, correct, and verifiable insurance information, we will file your insurance claim as a courtesy to you.
-We charge usual and customary rates (UCR) for our area. Your plan may have fee limits that are less than our fees and you are required to pay the difference. In some cases, you may not have coverage at all. **You are responsible for verifying your own coverage before services are rendered.**
- Should you exceed your annual insurance benefits ("Max Out"), you will receive a bill for your balance from our office, which is due upon receipt.
-Please be aware that outstanding dental claims at other offices may affect the insurance ESTIMATES we provide.

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**Upon completion of your treatment, if you are not paying in full for ANY reason, (insurance, payment plans, etc.) you must provide your social security number (SS#) to establish credit with our office.**

If you choose not to provide your SS#, then you must pay in full upon completion of treatment.

**Please ask any questions about our financial policy or fees, before treatment begins, to avoid misunderstandings.**

-I understand that root canal therapy is an attempt to retain a tooth that may otherwise require extraction, and there are risks involved with treatment. These risks include: instruments broken within the root canals; perforations (extra openings) of the crown or root of the tooth; damage to bridges, existing fillings, crowns or porcelain veneers; loss of tooth structure in gaining access to canals; and cracked (fractured) teeth. During treatment, complications may be caused by: blocked canals due to fillings, prior treatment, natural calcifications, or broken instruments; curved roots; periodontal disease; and cracks or fractures of teeth. I acknowledge that I understand these risks and have consented to treatment in this office.
-I understand that the fees charged to me for my care might not be covered by my insurance or may exceed my plan benefits. I am aware that I am financially responsible to my provider for the entire treatment.

SIGN HERE TO AGREE TO TREATMENT AND FINANCIAL POLICIES

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Signature of PATIENT or GUARDIAN Date