WELCOME TO OUR OFFICE

Patient comfort is our primary concern. Our goal is to alleviate apprehension and to provide the finest care. Every patient is important to us and benefits from the most advanced technology available for endodontic treatment. In out office we use the surgical operating microscope which offers increased magnification and illumination for all procedures.

BASIC ENDODONTIC OBJECTIVES:
Endodontic treatment consists of cleaning, shaping, and filling the internal root canal space of a tooth. The number of appointments needed to accomplish this varies, depending upon: which tooth is treated; amount of infection or pain initially present; complexity of the case; and each individual's healing response. Normally, most teeth can be completed in two visits or less.

Root canal treatment is an attempt to retain the tooth, which may otherwise require extraction. Although root canal treatment has a high rate of success, it cannot be guaranteed. Occasionally a tooth that has a root canal treatment may require re-treatment, surgery or even extraction.

HEALTH HISTORY:
All patients or parents of a minor will be asked to complete a brief medical history form.

CONSULTATION:
A diagnostic x-ray will be taken and developed immediately. The doctor will examine and test the teeth in question and the surrounding tissues. Treatment of the case will be discussed. There is a fee for any consultation, whether or not endodontic treatment is instituted.

DENTAL INSURANCE:
Your insurance is a contract between you, your employer or labor union and your insurance carrier. Please submit the insurance information to us before completion of your treatment. We will bill the insurance company as a courtesy. Any questions about insurance should be discussed with our office before treatment is begun. It is your responsibility to be informed about your insurance benefits, it is not our responsibility.

METHOD OF PAYMENT:
Payment is due at the time of treatment. If you have dental insurance, a percentage will be due at the start of treatment. The percentage is only an estimate, as you are ultimately responsible for the balance. Please indicate which of the following methods of payment you will be using.

CASH --------- CHECK ---------VISA, MASTERCARD, DISCOVER OR AMEX---------

DELINQUENT ACCOUNTS:
A service charge of 2% per month / 24% per annum (but in no event more than the maximum rate permissible under state law) will be charged on any unpaid balance due from the patient at the time of service. Any patient balance inactive for 60 days will automatically be turned over to a collection agency. A charge of $30.00 will be added to the account to cover the additional costs.

FINAL RESTORATIONS:
Endodontic treatment does not include placing the permanent filling or post and core build-ups on the tooth. You will be referred back to your general dentist for a final restoration such as a crown or filling. This is your responsibility and is necessary to safeguard the tooth.

LAB FEES:
If it is necessary for us to order a laboratory test (such as culture or biopsy), you will be billed directly by them and are responsible for payment of that bill.

AGREEMENT:
As a patient or legal guardian of a minor patient, I agree to pay for all services rendered in accordance with the terms and conditions set forth in the financial policy. In the event that legal action should become necessary to enforce payment of any charges, I agree to be responsible for all reasonable legal cost incurred.

Date Patient or Guardian's Signature

TAD T. SUZUKI, D.D.S, INC. **ROBERT D. BRENNAN, D.D.S., INC.**

CONSENT AND INFORMATION FORM

Regarding Health history, Endodontic (Root Canal) Therapy, Pre Medication
Local Anesthetic and Medication.

It is the belief of this office that you should be informed about the treatment (therapy) and that you should give your consent before starting that treatment. The purpose of this consent is to tell the risks that may occur in the endodontic (root canal) treatment, and other treatment choices.

Root canal treatment is done in order to retain a tooth (or teeth) which otherwise might need to be removed. Related dental surgery is done when needed.

Risks of treatment are two kinds: those risks involved in general dental procedures, and those risks specific to endodontic treatment.

RISKS OF DENTAL PROCEDURES IN GENERAL: include but are not limited to: complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness, and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, thrombophlebitis (inflamation to a vein), reaction to injections, change in occlusion, muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues, referred pain to the ear, neck, and head, nausea, vomiting, allergic reactions (itching, bruises, delayed healing, sinus complications, and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY: 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 teeth. During treatment, complications may be discovered which make treatment impossible, or which may require dental surgery. These complications may include: blocked canals due to fillings, prior treatment, natural calcification, broken instruments, curved roots, periodontal disease (gum disease), splits or fractures of teeth.

OTHER TREATMENT CHOICES include: no treatment, waiting for more definite development of symptoms, having the tooth removed, obtaining a second opinion. Risks involved in these choices might include pain, swelling, infection, and loss of tooth. Treatment will be done in a manner to minimize or avoid risks as success cannot be guaranteed.

I understand that upon my request I may receive a copy of this form. I also understand that upon completion of my root canal therapy in this office, I will be directed to return to my general dentist for a permanent restoration such as a crown or filling. If I do not return to my general dentist for the final restoration in a timely manner (4-6 weeks), I will be responsible for any re-work or re-treatment. I, the undersigned, being the patient, or parent or guardian of minor patient consent to the performing of the procedures decided upon to be necessary or advisable in the opinion of the doctor on the tooth or tissue as listed.

Root canal treatment is an attempt to retain a tooth, which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth, which has had a root canal procedure, may require re-treatment, surgery or even extraction.

DATE _____ REVIEWED BY _____

PATIENT SIGNATURE _____

TAD SUZUKI, D.D.S., INC. **ROBERT D. BRENNAN, D.D.S., INC.**

Date

Patient:'s Name (please print)

Mailing Address

City

State Zip

Physical Address

City

State Zip

Email

❑ Single ❑ Married Sex: ❑ Male ❑ Female

Patients Age

Home Phone Date of Birth

Cell Phone Soc. Sec. No.

Work Phone Driver's Lic. No.

Patient's Occupation

Patients's Employer

Referred By Dr.

FINANCIALLY RESPONSIBLE PERSON IF OTHER THAN PATIENT OR SPOUSE

First Name Middle intl. Last Name

Address

City State Zip

Sex: ❑ Male ❑ Female

Soc. Sec. No. Driver's Lic. No.

Home Phone No. Date of Birth

Cell Phone Work Phone No.

Occupation

Employer

City State Zip

Have you ever been treated in our office before? ❑ Yes ❑ No

If patient is over 18 years old and is a full time student:

Name of School

City

Primary Dental Insurance

Name of Insurance Company

Address

City

State Zip

ID/Agreement No. Group Name or No.

Subscriber's Name on Insurance coverage *(if different from patient's)*

Date of Birth Soc. Sec. No.

Employer's Name

How is this employee related to the patient?

❑ Subscriber ❑ Spouse ❑ Dependent

Secondary Dental Insurance

Name of Insurance Company

Address

City

State Zip

ID/Agreement No. Group Name or No.

Subscriber's Name on Insurance coverage *(if different from patient's)*

Date of Birth Soc. Sec. No.

Employer's Name

How is this employee related to the patient?

❑ Subscriber ❑ Spouse ❑ Dependent

I agree to be responsible for any charges not paid by my insurance company or if I am not covered by insurance.

Date Signature

PLEASE COMPLETE BACK SIDE OF THIS FORM

Patient's Name *(please print)*

Emergency Contact

Name

Address

Phone No.

1. General Health:

❑ Excellent ❑ Good ❑ Fair ❑ Poor

2. Are you under the ongoing care of a physician?

❑ Yes ❑ No

If yes, please explain _____

3. Name of family physician:

4. Are you wearing a pacemaker or heart valve prosthesis?

❑ Yes ❑ No

5. Have you been hospitalized or had a serious illness in the past five years?

❑ Yes ❑ No

If yes, please explain _____

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

❑ Yes ❑ No

7. Please list all medications that you are taking (prescribed and non-prescribed)

8. Have you ever taken Fen-Phen or related diet drugs? ❑ Yes ❑ No

9. Have you ever taken bisphosphonate for bone treatment? i.e. Fosamax, Actonel, Aredia, Zometa ❑ Yes ❑ No

10. Are you Pregnant?_____Months? ❑ Yes ❑ No

11. Have you ever undergone Root Canal Treatment? ❑ Yes ❑ No

Check any of the following to which you're allergic or have had an unusual reaction to:

❑ Penicillin	❑ Aspirin	❑ Demerol
❑ Sulfa Drugs	❑ Darvon	❑ Nitrous Oxide
❑ Erythromycin	❑ Codeine	❑ Steroids
❑ Novocaine (Xylocaine)	❑ Valium (tranquilizers)	❑ Other: _____
❑ Motrin	❑ Sedatives	
❑ Latex	❑ Barbiturates	

Is there anything else about your health we should know?

Do you have any Special needs? Do you require antibiotics prior to dental treatment?

What is your chief dental complaint?

Signature Date

Reviewed by_____

Name:_____ Date: _____

Do you now have or have you ever had any of the following? Please check appropriate boxes.
*If yes to any of the starred conditions, please call prior to your appointment... premedication may be required.

	Yes	No
Heart Trouble/Disease	☐	☐
Heart Murmur*	☐	☐
Irregular Heartbeat	☐	☐
Angina/Chest Pain	☐	☐
Heart Attack/Failure	☐	☐
Congenital Heart Disorder	☐	☐
Mitral Valve Prolapse*	☐	☐
Scarlet Fever	☐	☐
Rheumatic Fever*	☐	☐
Artificial Heart Valve*	☐	☐
Heart Pace Maker	☐	☐
Heart Surgery	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Blood Disease	☐	☐
Unexplained Fever	☐	☐

	Yes	No
Bruise Easily	☐	☐
Anemia	☐	☐
Excessive Bleeding	☐	☐
Sickle Cell Disease	☐	☐
Hemophilia (Bleeding Problem)	☐	☐
Leukemia	☐	☐
Recent Blood Transfusion	☐	☐
Swelling of Limbs	☐	☐
Lung Disease	☐	☐
Breathing Problems	☐	☐
Shortness of Breath	☐	☐
Frequent Cough	☐	☐
Hay Fever	☐	☐
Sinus Trouble	☐	☐
Asthma	☐	☐
Bloody Sputum	☐	☐

	Yes	No
Emphysema	☐	☐
Tuberculosis	☐	☐
Cancer	☐	☐
X-Ray Treatment (Radiation)	☐	☐
Chemotherapy	☐	☐
Stomach/Intestinal Disease	☐	☐
Ulcers	☐	☐
Recent Weight Loss	☐	☐
Frequent Diarrhea	☐	☐
Diabetes	☐	☐
Excessive Thirst	☐	☐
Hypoglycemia	☐	☐
Liver Disease	☐	☐
Hepatitis C (Infectious)	☐	☐
Hepatitis A or B	☐	☐
Night Sweats	☐	☐

	Yes	No
Yellow Jaundice	☐	☐
Kidney Problems	☐	☐
Renal Dialysis	☐	☐
Thyroid Disease	☐	☐
Parathyroid Disease	☐	☐
Arthritis/Gout	☐	☐
Rheumatism	☐	☐
Pain in Jaw Joints	☐	☐
Cortisone Medicine	☐	☐
Artificial Joint*	☐	☐
AIDS	☐	☐
HIV Positive	☐	☐
Drug Addiction/Alcoholism	☐	☐
Cold Sores	☐	☐
Fever Blisters	☐	☐
Herpes	☐	☐

	Yes	No
Stroke	☐	☐
Convulsions	☐	☐
Epilepsy or Seizures	☐	☐
Fainting or Dizziness	☐	☐
Glaucoma	☐	☐
Tumors or Growths	☐	☐
Nervousness	☐	☐
Psychiatric Care	☐	☐
Alzheimer's Diseases	☐	☐
Allergies (Medicines)	☐	☐
Allergies (Pollen/Dust)	☐	☐
Hives or Rash	☐	☐
History of Migraines	☐	☐
Need Premedication	☐	☐