Palo Alto Endodontic Center
850 Middlefield Rd., Suite 4
Palo Alto, CA 94301
(650) 485-2514/Fax: (650) 485-2511

CONSENT FOR ENDODONTIC EVALUATION & THERAPY

Please review the following consent form. You will be required to sign this form prior to the initiation of treatment. Your signature does not commit you to any treatment.

I understand the root canal (Endodontic) therapy is a procedure that retains a tooth, which may otherwise require extraction. As a specialty practice, this office performs only endodontic therapy and associated surgeries. Although root canal therapy has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth, which has had root canal therapy, may require retreatment, surgery, or even 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 full function, and your general dentist will perform these procedures. During endodontic treatment, there is the possibility of instrument separation within the root canals, perforations (extra openings), damage to bridges, existing fillings, crowns or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals, and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when the tooth may not be amenable to endodontic treatment at all. Other treatment choices include no treatment, a waiting period 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 possible spread of infection to other areas.

Occasionally, medication will be prescribed by our office. Medications prescribed for discomfort and/or sedation may cause drowsiness, which can be exacerbated by the use of alcohol or other drugs. We advise that you do not operate a motor vehicle or any hazardous device while taking such medications. In addition, certain medications may cause allergic reactions, such as hives or intestinal discomfort. If any of these problems occur, call our office or PCP immediately. It is the patient's responsibility to report any changes in his/her medical history to our office.

All of my questions will be answered by Dr. Reza Riahi/Dr. Brian Cheung and I fully understand the above statements in this consent form.

Furthermore, I give Dr. Reza Riahi/Dr. Brian Cheung my permission to voice record, tape digitally, or take digital photos of my procedure for purposes of completing my medical record and/or for patient education. Dr. Riahi/Dr. Cheung may, on occasion, use these digital records in lectures and for teaching at which time patient identity is kept strictly confidential and compliant to HIPAA protocols.

Note: All medical records will be kept strictly confidential.

Patient Signature _____ Date _____

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Patient Information Form

Today's Date: _____

Patient Name (Last) _____ (Middle) _____ (First) _____
Address _____, Apt/Unit___City _____State _____ Zip _____
Phone (Home) _____(Cell) _____(Work) _____
Email address: _____
In case of an emergency, who should be notified? _____
Relationship to Patient _____ Contact phone number _____

Social Security Number _____ Date of Birth _____
Gender ☐ Male ☐ Female ☐ Non-Binary Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced Widowed
Occupation _____Employer _____
Employer's Address _____City _____ State _____Zip _____

Dental Benefit Plan Information

Primary Dental Plan _____ Phone Number _____
Name of Primary Subscriber _____Date of Birth _____ ID Number _____
Secondary Dental Plan _____ Phone Number _____
Name of Primary Subscriber _____ Date of Birth _____ ID Number _____

Patient Responsibilities: We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

***(INITIAL)*_____Payment:** Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed prior to performing any treatment in our practice accept in certain emergency care. We accept the following forms of payment- CASH, CHECK, and all major Credit Cards, including Visa, Mastercard, Discover, and Amex.

***(INITIAL)*_____Dental Benefits Plans:** Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

(INITIAL)*_____*If we are a contracted provider with your plan, you are responsible only for your portion of the approved fees as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental plan) in full at time of service. If our estimate of your portion is less the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

(INITIAL)*_____*If we are not a contracted provider with your dental benefit plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

***(INITIAL)*_____Scheduling of Appointments:** We reserve the doctor's time on the schedule for each patient procedure and are diligent about being on- time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we require 48-hours notice to reschedule and appointment. With less than 48-hour notice, a fee $222.00 or deposit to reserve the appointment time again, may be required. To serve all patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of $222 or deposit to reserve the appointment time again, may be required.

***(INITIAL)*_____Authorizations:** I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. I have read the above and agree to the financial and scheduling terms. I hereby acknowledge the release of information necessary to process my dental benefit claims.I acknowledge that a copy of this practice's **Notice of Private Practices** and **Dental Material Fact Sheet** has been made available to me.

Signature _____ **Date**_____

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HEALTH HISTORY FORM

Today's Date: _____ General Dentist: _____

Patient Name: _____ Date of Birth: _____

How would you describe your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

1. Hospitalization for illness or injury ☐YES ☐NO
   If yes, briefly explain: _____
2. An allergic reaction to:
   - ☐Aspirin, ibuprofen, acetaminophen, codeine
   - ☐Penicillin
   - ☐Other antibiotics _____
   - ☐Local anesthetic _____
   - ☐Metals (nickel, gold, silver, _____)
   - ☐Latex
   - ☐Other _____
   - ☐NKDA (No Known Drug Allergies)
3. Heart defects ☐YES ☐NO
4. Heart murmurs ☐YES ☐NO
5. History of infective endocarditis ☐YES ☐NO
6. Pacemaker or implantable defibrillator ☐YES ☐NO
7. Artificial prosthesis (heart valve or joints) ☐YES ☐NO
8. Rheumatic or scarlet fever ☐YES ☐NO
9. High or low blood pressure ☐YES ☐NO
10. Stroke (take blood thinners) ☐YES ☐NO
11. Anemia or other blood disorder ☐YES ☐NO
12. Prolonged bleeding with a slight cut (INR >3.5) ☐YES ☐NO
13. Emphysema, shortness of breath, sarcoidosis ☐YES ☐NO
14. Tuberculosis, measles, chicken pox ☐YES ☐NO
15. Asthma ☐YES ☐NO
16. Breathing or sleeping problems (sleep apnea) ☐YES ☐NO
17. Kidney disease ☐YES ☐NO
18. Liver disease ☐YES ☐NO
19. Jaundice ☐YES ☐NO
20. Thyroid, parathyroid disease ☐YES ☐NO
21. Diabetes (HbA1c= _____) ☐YES ☐NO
22. Stomach or duodenal ulcer ☐YES ☐NO
23. Digestive disorders (i.e. celiac disease) ☐YES ☐NO
24. Osteoporosis/osteopenia ☐YES ☐NO
25. Are you taking bisphosphonates? ☐YES ☐NO
26. Arthritis, rheumatoid arthritis, lupus ☐YES ☐NO
27. Glaucoma ☐YES ☐NO
28. Head or neck injuries ☐YES ☐NO
29. Epilepsy, convulsions (seizures) ☐YES ☐NO
30. Neurologic disorders ☐YES ☐NO
31. Viral infections or cold sores ☐YES ☐NO
32. Any lumps or swelling in the mouth ☐YES ☐NO
33. Hives, skin rash, hay fever ☐YES ☐NO
34. STI / STD ☐YES ☐NO
35. Hepatitis (Type ___) ☐YES ☐NO
36. HIV / AIDS ☐YES ☐NO
37. Tumor, abnormal growth ☐YES ☐NO
38. Radiation therapy ☐YES ☐NO
39. Chemotherapy, immunosuppressive ☐YES ☐NO
40. Cholesterol ☐YES ☐NO
41. Psychiatric treatment ☐YES ☐NO
42. Antidepressant medication ☐YES ☐NO
43. Alcohol (daily, weekly, socially) ☐YES ☐NO
44. Recreational Drugs ☐YES ☐NO

ARE YOU:

45. Presently being treated for any other illness ☐YES ☐NO
    If yes, briefly explain:_____ _____
46. Aware of a change in your health in the last 48 hours (i.e. fever, chills, new cough, or diarrhea) ☐YES ☐NO
47. Taking medications for weight management ☐YES ☐NO
48. Experiencing or have vertigo ☐YES ☐NO
49. Often exhausted or fatigued ☐YES ☐NO
50. Experiencing frequent headaches ☐YES ☐NO
51. Smoker (currently, previously) ☐YES ☐NO
52. FEMALE – Taking birth control ☐YES ☐NO
53. FEMALE – Pregnant; how many weeks? _____ ☐YES ☐NO
54. FEMALE – Nursing ☐YES ☐NO

List all medications, supplements, and/or vitamins you are currently taking: _____

_____

_____

Patients Signature: _____ Date: _____

Dentists Signature: _____ Date: _____

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CLINICAL NOTES

Patient Name: _____ **Date of Birth:** _____

DATE	NOTES
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