

SINCE 2002

COX AND TAY

ENDODONTICS

DR. MATTHEW COX
DR. RONNEY TAY

660 S Green Valley Parkway, Suite 120,
Henderson, NV 89052

(702) 492-6688

Name: _____ Date of birth: _____ Social Security#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____ Occupation: _____

Dental Insurance: _____ Insured Name: _____

ID/SSN # _____ Date of birth: _____ Referring Dentist: _____

Pharmacy Info - Name: _____ Address: _____ Phone: _____

Current Problem Circle any symptoms you have or have had with this tooth:

Pain to cold/hot Pain to biting/touching Pain on its own Swelling Swollen lymph glands

How long have you experienced these symptoms? _____

How are you feeling today? Confident/ Happy Scared/ Nervous Angry/ Frustrated Skeptical/ Confused

Medical History

Have you had any of the following:

Prosthetic joint / valve	YES	NO
Date : _____		
Infective endocarditis	YES	NO
Congenital heart disease	YES	NO
Cardiac Transplant	YES	NO

Please list all medications you are taking and the reason you are taking it -

Medication:	Reason:
_____	_____
_____	_____
_____	_____

Have you ever been instructed by a physician or dentist to **ROUTINELY** take antibiotics before every dental procedure? YES NO

Please CIRCLE the medical conditions you have/had:

Have you ever taken any of the following medications (commonly used in treating osteoporosis and some cancer therapies):

- Alendronate (Fosamax, Binosto),
- Risedronate (Actonel, Atelvia),
- Ibandronate (Boniva),
- Zoledronate (Zometa, Reclast),
- Denosumab (Prolia, Xgeva)
- Pamidronate (Aredia),
- Neridronate, or
- Olpadronate? YES NO

heart problems	liver problems
heart attack date: _____	diabetes
heart surgery date: _____	osteoporosis
stroke date: _____	tuberculosis
pacemaker date: _____	HIV/AIDS
hepatitis – type(s): _____	alcoholism
high blood pressure	drug abuse
respiratory problems	TMJ
thyroid problems	emphysema
bleeding/clotting disorder	asthma
Seizures – most recent: _____	sinusitis
Inflammatory bowel disease	migraines
kidney problems	ulcers
fainting	glaucoma

Have you had cancer? YES NO
If yes, what type(s): _____

Please CIRCLE any of the following to which you are allergic or had an adverse reaction:

Has your jaw ever locked open?	YES	NO
Are you pregnant?	YES	NO
Are you nursing?	YES	NO
Are you taking birth control?	YES	NO

Epinephrine	Penicillin	Codeine	Latex
Ibuprofen	Clindamycin	Vicodin®/Lortab®	

Please list any other medical condition(s) you have:

Other: _____

Notice of Privacy Practices Patient Acknowledgement

I have received this practice's Notice of Privacy Practices written in plain language. The Notice describes the uses and disclosures of my protected health information that may be needed by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all provided health information resident at, or controlled by this practice. I understand I can obtain this practice's current Notice of Privacy Practices upon request.

Signature: (Patient/Guardian) _____ Date: _____

Consent for Root Canal Therapy

1. Root canal therapy has a high degree of success but as it is a biologic procedure, the results cannot be guaranteed.

Many factors influence the treatment outcome including the following: the bone support around the tooth, fracture lines and the shape and condition of the canals.

2. Teeth treated with root canals must be protected during treatment. Caution should be used when chewing on treated teeth since they have an increased potential to fracture until a crown is placed.

3. If the tooth has a crown or is part of a bridge, then there is a small risk that the crown or bridge will fracture or be dislodged during treatment. If this occurs, we may not be equipped to properly repair it and will recommend that you return to your dentist for any repairs that are needed.

4. The tooth is normally sensitive following appointments and even remains so for a few weeks after treatment is complete.

5. Fractures are one of the main reasons why root canals fail. Unfortunately, some cracks on the root are extremely difficult to detect. Whether it occurs before or after root canal therapy, it may require the extraction of the tooth.

6. Teeth treated with root canals can still decay. As with all of your teeth, proper care consists of good oral hygiene, a sensible diet, and periodic dental cleanings and check-ups.

7. With some teeth, a root canal alone may not be sufficient. For example, if the canal(s) are severely bent and/or calcified, if there is a substantial infection around the roots, or if there is a broken instrument within the canal, the tooth may remain sensitive and a surgical procedure or extraction may be necessary to resolve the problem.

8. Like most medical/dental procedures, there exist several potential risks. These include the following: swelling; pain; infection; numbness in the lip, tongue, chin, gums, cheeks, and teeth, which is transient but on infrequent occasions may be permanent; reactions to injections or medications which in rare cases can be life-threatening; changes in biting; jaw muscle spasms; TMJ difficulty; referred pain to ear, neck, or head; sinus perforations; complications from the use of dental instruments: broken instruments, perforation of the root or sinus, discoloration of the face, reactions to medications causing drowsiness and lack of coordination.

9. There are alternatives to root canal therapy. They include the following:

1. No treatment at all (which may place you at risk)

2. Extraction of the tooth followed by no treatment, a bridge, a partial, or an implant.

10. AFTER ROOT CANAL THERAPY, THERE WILL BE A TEMPORARY FILLING IN THE TOOTH. You should return to your general dentist for a *final* restoration as soon as possible.

11. Since teeth with root canals are weaker, your general dentist will probably recommend a crown. Thus, the cost to restore your tooth is **SEPARATE** from the cost of root canal treatment.

The diagnosis, prognosis, and nature of root canal treatment have been explained to me and I have had a chance to ask questions. I understand that the success of root canal treatment cannot be guaranteed. I authorize Dr. Cox, Dr. Tay and his assistants to proceed with treatment.

Signature: (Patient/Guardian) _____ Date: _____

Financial Agreement

Payment for dental treatment, including insurance co-pays, is due at the time of service.

I agree to be responsible for all charges for dental services not paid by my dental insurance. **I understand that I am electing to have treatment without a written pre-authorization, and thus my dental insurance may pay less than or no part of services today.**

To the extent permitted under applicable law, I authorize release of any information relating to this claim. I also agree to be responsible for any costs of collection that Cox and Tay Endodontics may incur as a result of this account being placed with an outside collection agency. This amount will include a fee of up to **35%** of the amount assigned for collection and also agree to be responsible for any attorney fees or court costs that may be awarded by a court of jurisdiction. NSF checks will be charged \$25. I also authorize payment of the dental benefits otherwise payable to me directly to the practice of the treating dentist.

Signature: (Patient/Guardian) _____ Date: _____