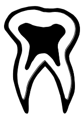

Matthew O. Cox, D.D.S. *Practice Limited to Endodontics*

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: _________________

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

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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

Have you ever been instructed by a physician or dentist to ***ROUTINELY*** take antibiotics prior to dental procedures?   YES   NO

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

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

Have you had cancer?   YES   NO

If yes, what type(s): ____________________

Has your jaw ever locked open?   YES   NO

Are you pregnant or nursing?   YES   NO

Are you taking birth control?   YES   NO

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

____

____

____

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

Medication:	Reason:
________________	________________
________________	________________
________________	________________
________________	________________

Please CIRCLE the medical conditions you have/had:

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

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

Epinephrine	penicillin	codeine	LATEX
ibuprofen	clindamycin	Vicodin®/Lortab®	

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 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 Matthew O. Cox, D.D.S 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: ______________________