Sierra Endodontics

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9456 Double R Blvd., Suite A, Reno, NV 89521
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PATIENT REGISTRATION

WELCOME TO OUR PRACTICE. THANK YOU FOR PROVIDING THE FOLLOWING CONFIDENTIAL INFORMATION SO THAT WE CAN PROVIDE FOR YOUR NEEDS IN A SAFE AND COMFORTABLE MANNER.

PATIENT INFORMATION (Please Print)

Title (Please Circle One) Dr. Mr. Mrs. Ms. Miss

Name _____
(First) (M/I) (Last)

Birth Date _____ Social Security # _____

Mailing Address _____
(Street) (City) (State) (Zip)

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Employer (Parent's Employer If Minor) _____

Parent's Name _____ Spouse's Name _____
(If Patient Is a Minor)

Spouse's Employer _____

Whom May We Contact In Case Of Emergency? _____

Relationship _____ Phone # _____

Whom May We Thank For Referring You to Us? _____

With whom may we share your dental information? _____

Dental Insurance Information: Insurance Company _____

Insurance Address _____ Insurance Phone # _____

Insured's Name _____ Birth Date _____

Group # _____ ID # _____

Who is Financially Responsible For This Bill? _____
(Please Read and Sign Financial Policy and Insurance Form)

I Will Be Paying Today By (Please Circle One) Cash Check Credit Card

(OVER)

MEDICAL and DENTAL HISTORY

Your medical history is important to us. Please answer all questions regarding your current and past health status as completely as possible. You can be assured that all information provided will be held in strict confidence according to our posted privacy policies.

For what reason have you been referred to our office? _____

MEDICAL HISTORY

Primary Care Physician's Name _____ Phone Number _____

Pharmacy_____

Please circle "Yes" or "No" for each of the following:

Yes	No	Heart Attack/Angina	Yes	No	Tuberculosis	Yes	No	Drug or Alcohol Dependency
Yes	No	Stroke	Yes	No	Lung Disease	Yes	No	Problem with Immune System
Yes	No	Diabetes	Yes	No	Liver Disease/Hepatitis	Yes	No	Herpes/Cold Sores
Yes	No	High Blood Pressure	Yes	No	Kidney Disease	Yes	No	Tobacco use
Yes	No	Cancer	Yes	No	Gastrointestinal Disease C. Diff, Colitis	Yes	No	Chest Pain
Yes	No	Heart Defect	Yes	No	Anemia	Yes	No	Shortness of Breath
Yes	No	Rheumatic Heart Disease	Yes	No	Epilepsy/Seizures	Yes	No	Swollen Ankles
Yes	No	Heart Valve Replacement	Yes	No	Glaucoma	Yes	No	Excessive Thirst or Urination
Yes	No	Pacemaker	Yes	No	Radiation/Chemotherapy	Yes	No	Dizziness
Yes	No	Asthma	Yes	No	Prosthetic Joint	Yes	No	Fainting Tendency
Yes	No	Chronic cough > 3 weeks	Yes	No	Bleeding Disorder	Yes	No	Headache
Yes	No	Night Sweats	Yes	No	Bloody sputum	Yes	No	Unexplained weight loss
			Yes	No	Recent travel out of the U.S. or live in concentrated housing with or without another tuberculosis patient			

Other pertinent medical history: _____

Are you pregnant? _____ If yes, how many months? _____Could you be pregnant? _____ Are you breast feeding? _____

DENTAL HISTORY

Please circle "Yes" or "No" for each of the following:

Yes	No	Are you Currently in Pain	Yes	No	White or Yellow Drainage	Yes	No	Numbness or Tingling
Yes	No	Pain with Biting	Yes	No	Swollen Lymph Nodes	Yes	No	Pain in Jaws
Yes	No	Pain to Hot Food or Drink	Yes	No	Fever	Yes	No	Difficulty Opening Mouth
Yes	No	Pain to Cold Food or Drink	Yes	No	Sinus Pain	Yes	No	Previous Root Canal
Yes	No	Gum Tenderness	Yes	No	Neck or Facial Swelling	Yes	No	Severe Dental Anxiety

Other pertinent dental history: _____

MEDICATIONS AND ALLERGIES

List Current Medications (including prescribed, over the counter, and contraceptive medications): _____

List All Allergies (such as antibiotics, local anesthetic, pain medications, ibuprofen, latex, or foods): _____

Have you received or are you currently receiving medication known as bisphosphonates (for example; zoledronic acid [Zometia], pamidronate [Aredia], alendronate [Fosamax], risedronate [Actonel], or ibandronate [Boniva]): _____ If yes, how long? _____

Do you need antibiotics prior to dental appointments? _____ If yes, why? _____

Have you taken steroids in the past year? _____ If yes, when and at what dosage? _____

Can you take Ibuprofen? _____ Yes_____ No If no, why_____

The above medical history is true to the best of my knowledge. Furthermore, I have been offered a copy of this office's Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Designate Date

_____

Print Name

For office use only

BP: _____ / _____

Pulse: _____

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FINANCIAL POLICY AND DENTAL INSURANCE

We are committed to provide you the best possible care. If you have dental insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

We will be happy to file your insurance claim for reimbursement. You will be asked to pay your "estimated portion", or co-pay, on the day of treatment. We accept cash, checks, Mastercard, Visa, American Express, and Discover. Our computer estimates the amount due based upon information given to us by the insurance companies and previously filed claims for the same companies. Your "estimated portion" is just that, an estimate, not a guarantee of payment from the insurance company on your behalf. Following payment from the insurance company, we will send a statement to you for the difference between the estimate and the actual amount paid for the claim.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. If your insurance company fails to reimburse this office for services rendered within 60 days, the balance will become the responsibility of you, the patient, and will be due at that time. We recommend monitoring the status of your claim periodically with your insurance company to avoid this situation.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

I _____ have reviewed the financial policies of this office and the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

I hereby authorize payment of the dental benefits otherwise payable to me directly to the above name dental entity.

_____ _____

Signature of Patient or Legal Designate Date

_____

Print Name

(OVER)

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CONSENT FOR ENDODONTIC TREATMENT

I _____ understand that root canal treatment is a procedure to retain a tooth which may otherwise require extraction. I have been informed of possible alternative methods of treatment, including no treatment, and the possible benefits or adverse results from these alternative treatments.

I understand that root canal treatment can have a very high degree of clinical success (85-95% of routine cases are successful); however, as with any branch of medicine or dentistry, no guarantee of successful treatment can be given or implied. Occasionally, a tooth which has had root canal treatment may require revision (retreatment), a surgical procedure, or even extraction.

Treatment will be performed in accordance with accepted methods of clinical practice. This will require the administration of local anesthetic agents and placement of a rubber dam. In addition, a number of radiographs (X-rays) will be necessary to accomplish the root canal procedure. The number of radiographs will vary with the complexity of the case.

I have been informed and understand that there are certain inherent and potential risks in any treatment procedure. These include swelling; bruising; bleeding; discomfort; infection; numbness or tingling of the lips, tongue and/or jaw; and difficulty in opening or closing the jaw. Most of these complications are temporary in nature, but it is possible to have permanent changes in the form of pain, numbness, or tingling in lips, tongue, and/or jaw. Fractures of existing restorations (especially porcelain crowns), the tooth, and/or instruments used to perform the treatment may occur. Additionally, variations in canal shape and size may complicate treatment and result in perforation (hole) in the root or a root canal filling that is less than desirable. Additional unknown or unspecified problems may occur, the explanation for and the responsibility of which cannot be given or assumed.

I understand that to accomplish the root canal procedure it is necessary to alter the existing tooth structure and/or restorations. These alterations require the placement of a new restoration or crown following endodontic therapy to protect the tooth from fracturing and subsequent loss of the tooth. The fee for endodontic treatment does not include these restorative procedures. In addition, I understand that it is my responsibility to have an appropriate restoration placed as soon as possible (within 30 days) by my general dentist following the root canal procedure.

Female Patients Only: The administration of antibiotics may decrease the efficacy of oral contraceptive medications. For this reason, additional barrier contraceptive methods should be employed for one month.

I understand that I am free to withdraw my consent and discontinue treatment at any time; however, complications such as bone destruction, infection and swelling, tooth loss, and/or pain, etc. may predictably occur if the root canal treatment is not completed. I also understand that periodic recall examination of the tooth including radiographs is recommended to evaluate the success of the treatment rendered and compliance with these appointments is my responsibility.

Any and all questions pertaining to diagnosis and treatment have been answered to my satisfaction the treating doctor prior to signing this form.

_____ _____

Signature of Patient or Legal Designate Date

_____ Tooth # _____

Print Name

_____ _____

Signature of Witness Date