FRANK HERNANDEZ, DMD, PA
endodontics

PATIENT'S NAME ______________________ Date of Birth ______________

Home Address ______________________ Phone ______________

City ______________________ State ________ Zip ________

Dental Insurance ______________________ Employer ______________

MEDICAL HISTORY

HAVE YOU EVER HAD

Heart Murmur	Yes ☐	No ☐
Heart Disease	Yes ☐	No ☐
Rheumatic Fever	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐
Liver Disease	Yes ☐	No ☐
HIV Positive	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐
Lung Disease	Yes ☐	No ☐
Excessive Bleeding	Yes ☐	No ☐
Thyroid Problems	Yes ☐	No ☐
Pacemaker	Yes ☐	No ☐

Please list any medical problems.

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ARE YOU PREGNANT? Yes ☐ No ☐

Have you had any surgery in the past year?
Yes ☐ No ☐

ARE YOU ALLERGIC TO:

Aspirin	Yes ☐	No ☐
Penicillin	Yes ☐	No ☐
Local Anesthetic	Yes ☐	No ☐
Codeine	Yes ☐	No ☐
Latex	Yes ☐	No ☐
Any Other Drugs	Yes ☐	No ☐

WHAT ______________________

Please list current medications.

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Dr. ______________________
Primary Care Doctor Phone

OUR PAYMENT POLICY

Payment is due at the time of service. Insurance is filed as a courtesy. Please feel free to discuss the treatment and/or fee with us at any time.

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Signature of Patient or Responsible Party

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ENDODONTIC CONSENT AND INFORMATION FORM

We would like our patients to be informed about the various procedures involved in endodontic therapy and have their consent before starting treatment. Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to be removed. Conservative root canal therapy, or when needed, endodontic surgery accomplishes this. The following discusses possible risks that may occur from endodontic treatment, and other treatment choices.

RISKS: The risks include the possibility of 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 or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), or splits or fractures of the teeth.

MEDICATIONS: Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs). it is not advisable to operate any vehicle or hazardous device until recovered from their effects.

OTHER TREATMENT CHOICES: These include no treatment (waiting for more definite development of symptoms) or tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infection of other areas.

CONSENT: I, the undersigned, being the patient (parent or guardian of minor patient) consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. I also understand that upon completion of root canal therapy in this office I shall return to my general dentist for a permanent restoration to the tooth involved, such as a crown, cap, jacket, onlay or filling.

I understand that root canal treatment is an attempt to save 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 root canal therapy, may require re-treatment, surgery or even extraction.

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DATE PATIENT / PARENT SIGNATURE

POS Reorder # 1808803