Joel. B. Slingbaum D.M.D.
Hallie R. Landy D.M.D.
Practice Limited to Endodontics

Please Print

Name ______________________ Date of Birth ______________

Home Address ______________________

City ______________ State ______________ Zip ______________

Home Phone ______________ Cell Phone ______________

SSN# or ID# ______________ Marital Status S M D W

Occupation ______________ Business Phone ______________

Employed By ______________________

Business Address ______________ Zip ______________

Person Financially Responsible by ______________________

Referred by ______________________

Physician ______________ Phone ______________

Nearest Relative ______________________

Relationship ______________________

Address ______________ Phone ______________

Employees Name who has the insurance coverage ______________________

Date of Birth ______________ SSN# or ID# ______________

Employer's Name ______________________

Address ______________________

Name of Insurance Company ______________________

Address ______________________

City ______________ State ______________ Zip ______________

Group Number ______________________

How is the Employee related to Patient? ☐ Subscriber ☐ Spouse ☐ Dependant

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ENDODONTIC (ROOT CANAL) INFORMED CONSENT

1. The purpose of root canal therapy is to retain teeth that would otherwise have to be extracted.

2. Treatment may require multiple visits. It is important that you maintain scheduled appointments or the infection can reoccur.

3. In most cases, there is only mild discomfort following each treatment. This is usually controlled with Aspirin, Tylenol, Ibuprofen, or prescribed medication.

4. Endodontic treatment has a high degree of success. As any medical or dental treatment, however, this treatment has no guarantee of success for any length of time. Teeth with previous root canal treatment will have a lower success rate.

5. Accurate and complete disclosure of medical information is necessary for proper diagnosis, and to help prevent unnecessary complication during your visit.

6. The most common complications with root canal therapy include, but are not limited to:
    a. Continued infection requiring endodontic (root canal) surgery or extraction of the tooth.
    b. Calcified canals or canals blocked by broken instruments requiring endodontic (root canal) surgery or extraction of the tooth.
    c. Pain, requiring use of medication.
    d. Side effects and reactions of medication.
    e. Fractures (breaking) of the root or crown of the tooth during or after treatment. It is recommended that all posterior teeth be crowned following root canal treatment. If your tooth already has a crown, there is a chance it will need to be replaced due to decay or loss of structural support. Porcelain crowns are subject to breakage.
    f. Tenderness of the tooth following treatment due to possible complication with root canal treatment, gum disease, physical stress from chewing, or the degree of healing your body exhibits.
    g. Anesthetic risks include: discomfort, swelling, bruising, infection, prolonged numbness and allergic reactions. There may be inflammation at the site of the injection.

7. Other treatment choices include no treatment, waiting for more definite development of symptoms, and tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infection to other areas.

8. if you have any questions, please ask.

Date:_________________________ Signature: ____

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PLEASE READ

We shall try to advise you as to the outcome, the number of appointments necessary, what you may expect from the treatment and the fees.

Fees are quoted in advance of the treatment. If this has been neglected please don't hesitate to ask. Fees once quoted remain the same except:

1. When appointments are broken without proper advance notification.
2. If surgery or re treatment becomes necessary.
3. When scheduled appointments are not rescheduled with our office.

If for any reason you will not be able to be treated for one month between visits, this may lead to further complications, possible recurrent or persistent infection which may lead to increased chance of failure or loss of tooth. Once this happens, other expenses will be incurred to re-initiate treatment, but the likelihood of success decreases. Therefore, sequence of treatment is an important factor in the success of your treatment. If there is deviation from the proposed treatment plan, further complications may lead to loss of the ability to save your tooth and extraction may be indicated.

When treatment is completed, your tooth will need a final restoration. Our fees do not include this necessary service. Your dentist will render this service which is equally important to the preservation of your tooth.

Our policy is that payment shall be completed by your last visit. Please arrange this with our receptionist. If your treatment is covered by insurance, we will expect a percentage of the fee from the patient. Your insurance company will be billed for services rendered. **Any remaining balance once your insurance pays is your responsibility. This office cannot be responsible for collecting your insurance claim or for negotiating a settlement on a disputed claim. Insurance is not a substitute for payment.** Your eventual reimbursement will be determined by your insurance carriers.

I do understand that I did sign an agreement with this office to take full responsibility for all services rendered. My failure to do so will result in demand for payment in full and my account to be turned over to collections for legal proceedings; the cost of which I will be fully responsible for. I also understand that an interest charge of 1.5% per month will go into effect on my unpaid balance over 60 days.

Fees quoted prior to treatment are estimates based on what the insurance company estimated your coverage to be.

_________________Please initial.

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DENTAL AND MEDICAL HISTORY

1. Date of last physical exam:______________________________
2. Are you in good health? ❑ Yes ❑ No
3. Are you under a physician's care? ❑ Yes ❑ No
   If yes, why? ______________________________
4. Are you taking any prescription medication or aspirin? ❑ Yes ❑ No
   If so, which and for what? ______________________________
5. Have you been hospitalized within the past year? ❑ Yes ❑ No
   If yes, please specify______________________________
6. If female, are you pregnant? ❑ Yes ❑ No
7. Are you on any form of birth control? ❑ Yes ❑ No
8. Have you ever had problems during dental treatment? ❑ Yes ❑ No
9. Are you allergic to or had an unusual reaction to anesthetic, drug, pill, or latex rubber? ❑ Yes ❑No
   List them:

Please circle if you have ever had:

Heart Surgery	Diabetes	Asthma	Venereal Disease
Heart Condition	Low Blood Sugar	Kidney Problem	Liver Problem
Heart Murmur	Gastrointestinal Problem	Bleeding Problem	Hepatitis
Rheumatic Fever	Thyroid Disease	Stroke	Epilepsy
High Blood Pressure	T.B. or Lung Problem	Jaundice	Ulcers
Blood Transfusion	Head/Neck Radiation	Anemia	Cancer
Chemotherapy	Psyc. Treatment	Glaucoma	HIV

Do you need antibiotics before dental visits due to? ______________________________

Bleeding ______________________________

Other______________________________

The completion of my medical history is accurate. I have read and understand all of the above information, including the informed consent and agree to the same.

SIGNATURE______________________________DATE______________

WITNESS ______________________________DATE______________