PATIENT INFORMATION

PLEASE FILL OUT COMPLETELY

NAME: (LAST)_____**(FIRST)**_____**(MID. INT)**_____

ADDRESS_____

CITY_____**STATE**_____**ZIPCODE**_____

TELEPHONE (HOME)_____**(WORK)**_____**(CELL)**_____

EMAIL_____**MARTIAL STATUS**_____**SS#**_____

DATE OF BIRTH_____**REFERRING DENTIST**_____

PATIENT EMPLOYER AND ADDRESS_____

_____

WHO TO CALL IN CASE OF AN EMERGENCY: (NAME)_____

(PHONE)_____

DENTAL CARD HOLDER INFORMATION:

NAME OF INSURED_____**EMPLOYER**_____

INSURANCE COMPANY NAME_____**ADDRESS**_____

_____**PHONE**_____

DATE OF BIRTH_____**SS#**_____

RESPONSIBLE PARTY IF OTHER THAN THE PATIENT ABOVE OR PATIENT IS A MINOR:

NAME_____**ADDRESSS**_____

CITY_____**STATE**_____**ZIPCODE**_____**TELEPHONE**_____

MOTHER'S SS#_____**FATHER'S SS**_____

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Name_____Physician_____

CHECK ANY OF THE FOLLOWING YOU HAVE HAD OR PRESENTLY HAVE OR HAD

__Anxiety
__Asthma
__Cancer
__Claustrophobic
__Diabetes
__Excessive Bleeding
__Heart Murmur
__Hiatal Hernia
__High Blood Pressure
__HIV Positive
__Radiation Therapy
__Prosthetic Joints
__Stroke
__Ulcers
__Kidney, Liver or Lung Disease
__Gag Reflex
__Hepatitis A, B, or C
__Heart Trouble
__Osteoporosis
__Heart Palpitations

Are you allergic or had an adverse reaction to:

__Codeine/Hydrocodone
__Keflex/Cephalexin
__Penicillin/Amoxicillin
__Erythromycin
__Doxycycline/Tetracycline
__Latex
__Aspirin/Ibuprofen/NSAIDS
__Other Allergies_____

Are you taking any medications?

Medication	Dosage	Reason For Taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you taken bisphosphonate(Actonel, Boniva, Fosamax, Fosamax D, Skelid, Didronel) orally or IV for any condition currently or in the past? If so, please explain?

_____

_____

Are you under a physician's care now? If so, for what?_____

Have you ever been told to be pre-medicated for dental work? _____

Females-Are you pregnant?_____

What is your chief dental complaint?_____

Sensitive?_____Hot?_____ Is there swelling?_____

Do you have biting & chewing pain_____

Is there any other medical or dental information that you feel I should know about?

_____

Patient/Guardian Signature_____Date_____

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Endodontic Consent and Information Form

We want to inform our patients about the various procedures involved in endodontic therapy and have their consent before starting treatment. Endodontic (root canal) therapy is performed to save a tooth which otherwise might need to be removed. The alternatives to endodontic therapy include no treatment, waiting for more definitive development of symptoms, and tooth extraction. Risks involved in these choices include pain, infection, swelling, and tooth loss.

Although root canal treatment has a very high degree of success (about 90%), it cannot be guaranteed. Pre-conditions of the tooth may decrease the success rate. If the original treatment is not successful, it may have to be redone, a surgical procedure may need to be required, or the tooth to be removed.

Due to the intricate nature of treatment, procedural problems can occur.
Possible complications of a root canal therapy included but not limited to:

1: Separation of root canal cleaning instrument in the canal
2: Swelling, soreness, infection
3: Fracture of crowns
4: Perforation of the root
5: Underfilled or overfilled canal filling material
6: Blocked canals due to filling or prior treatment, natural calcifications, severely curved roots or abnormal anatomy of the canals.

Upon completion of root canal treatment, you will need to return to your general dentist for construction of a crown or to evaluate the need for one.

A number of X-Rays will be needed throughout the root canal therapy.

Almost always a local anesthetic will be needed to anesthetize (numb) your tooth, just like when you go to your dentist to get a tooth filled. Although complications are rare, they include but are not limited to the following: sensitivity, swelling, numbness and tingling sensation, jaw muscle spasm, rapid heartbeat, and allergic reactions.

I fully understand the above statements in the consent form. I hereby give my consent to the performance of endodontic therapy to be administered by Dr. Lawson or his supervised staff for diagnostic purposes or dental treatment.

Name of Patient or Responsible Party:_____

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Deemed Consent Form

Code of Virginia § 32.1-45.1. Deemed consent to testing and release of test results related to infection with human immunodeficiency virus or hepatitis B or C viruses.

A. Whenever any health care provider, or any person employed by or under the direction and control of a health care provider, is directly exposed to body fluids of a patient in a manner that may, according to the then current guidelines of the Centers for Disease Control and Prevention, transmit human immunodeficiency virus or hepatitis B or C viruses, the patient whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus or hepatitis B or C viruses. Such patient shall also be deemed to have consented to the release of such test results to the person who was exposed. In other than emergency situations, it shall be the responsibility of the health care provider to inform patients of this provision prior to providing them with health care services which create a risk of such exposure.

B. Whenever any patient is directly exposed to body fluids of a health care provider, or of any person employed by or under the direction and control of a health care provider, in a manner that may, according to the then current guidelines of the Centers for Disease Control and Prevention, transmit human immunodeficiency virus or hepatitis B or C viruses, the person whose body fluids were involved in the exposure shall be deemed to have consented to testing for infection with human immunodeficiency virus or hepatitis B or C viruses. Such person shall also be deemed to have consented to the release of such test results to the patient who was exposed.

I fully understand the above statements in the consent form. I hereby give my consent to fully cooperate in acknowledgement of the Code of Virginia § 32.1-45.1., with Dr. Lawson and his supervised staff if such a situation arises during treatment.

Name of Patient or Responsible Party:_____

Signature:_____ Date:_____