Print Reset

PATIENT REGISTRATION

DOMINION ENDODONTICS
BRUCE W. OVERTON, D.D.S.
GARDINER M. PACKER, D.D.S., M.S.D.

6037 HARBOUR PARK DRIVE
MIDLOTHIAN, VA 23112
Telephone (804) 744-3636

Date _____

Name _____ _____ _____ Preferred Name _____
(Last) (First) (MI)

Address _____ _____ Phone: Home _____
(Street) (Apt #)

_____ ____ _____ Work _____
(City) (St) (Zip)

Sex ◯ M ◯ F SSN # _____ ◯ Single ◯ Married Cell _____

Age _____ Date of Birth _____ Spouse Work Phone (if applicable) Work _____

(Guardian/Parent Name if under 18 _____) Spouse's Name _____

Patient Employed by _____ Spouse Employed by _____

Patient's Occupation _____ Spouse's Occupation _____

Business Address _____ Business Address _____

_____ _____

General Dentist _____ In Case of Emergency, who should be notified? _____ Phone _____

DENTAL INSURANCE - PRIMARY

Insurance Co. Name _____

Insured's Name _____ Relation _____

Date of Birth _____ SSN # _____

DENTAL INSURANCE - SECONDARY

Insurance Co. Name _____

Insured's Name _____ Relation _____

Date of Birth _____ SSN # _____

MEDICAL HISTORY

Please check all that apply

- ☐ Artificial Heart Valves or Joints
- ☐ Blood Disease, Anemia
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Circulatory Problems, Stroke
- ☐ Diabetes
- ☐ Epilepsy, Seizures
- ☐ General Allergies
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Heart Problems
- ☐ Heart Murmur, Mitral Valve Prolapse
- ☐ Hemophilia, Abnormal Bleeding
- ☐ High Blood Pressure
- ☐ Immunosuppressive Disorders
- ☐ Kidney Disease
- ☐ Low Blood Pressure
- ☐ Psychiatric Care
- ☐ Radiation Treatment, Chemotherapy
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Ulcer, Colitis

Do you have any drug allergies? Or, ever had an adverse reaction to any medication?

If so, what

Do you have a personal physician? ◯ No ◯ Yes Physician's Phone _____

Physician's Name _____

Are you currently under the care of a physician? ◯ No ◯ Yes Please explain

Are you taking any prescription/over-the-counter drugs? ◯ No ◯ Yes Please list each one

Please list any serious medical condition(s) that you have ever had

For Women

Are you taking birth control pills? ◯ No ◯ Yes

Do you suspect that you are pregnant? ◯ No ◯ Yes

Are you nursing? ◯ No ◯ Yes

Endodontic Information & Consent

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 definite development of symptoms, and tooth extraction. Risks involved In these choices might include pain, infection, swelling, and tooth loss.

Endodontics or root canal therapy is the cleaning, shaping, disinfecting, and filling of the root canal(s) of the diseased tooth. The root canal is the space inside of the root of the tooth. A treated tooth usually functions normally and is a pulpless tooth, not a dead tooth. Treatment will require one or more visits depending upon the condition of the tooth. Please be advised of the following:

1. As a rule, 90-95% of routine cases are successful. Endodontics, as with any branch of medicine or dentistry, is not an exact science. Thus no guarantee of treatment success can be given or implied. If the original treatment is not successful, it may have to be redone, a surgical procedure may be required, or the tooth may need to be removed.
2. Endodontic treatment started in other offices or re-treatment cases may have a different outcome than expected under optimal conditions.
3. Proper post-treatment restoration of the treated tooth is a necessity. Please contact your dentist soon after the completion of treatment here to see if a crown will be needed for your tooth. If needed, it is your dentist's responsibility to do this for you.
4. Possible unavoidable complications of endodontic therapy include (a) procedural difficulties in the course of treatment (b) swelling soreness, infection, trismus, or discoloration of the soft or hard tissues, (c) fracture of the filling or root of the tooth, (d) separation of root canal instruments during treatment, (e) perforation or stripping of the root with instruments, (f) underfills and overfills of the root canal; sinus perforation, (g) damage to bridges, existing fillings, crowns or veneers, (h) blocked canals due to fillings or prior treatment, natural calcifications, severely curved roots, and root resorptions.

Treatment will be performed in accordance with accepted methods of clinical practice. Included in the treatment will be the taking of a minimal number of x-rays as indicated by the needs of treatment

Almost always a local anesthetic will be needed to anesthetize (numb) your tooth. Although complications are rare, they can Include the following: swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth which is transient but on very infrequent occasions may be permanent: jaw muscle cramps and spasm, trismus, rapid heartbeat and allergic reactions.

If surgery is indicated for the treatment of your tooth after it has had endodondic treatment here or elsewhere, there is a 75-80% chance that this will result in the retention of the tooth. As with any medical procedure there are complications associated with such surgery. These include treatment failure, delayed healing, sinus perforation, swelling, discoloration, sensitivity, postoperative Infection, jaw muscle cramps and spasm, and numbness and tinging in the top, tongue, chin, gums, cheeks or teeth which is usually transient but which on very infrequent occasions may be permanent.

Prescribed pain medications 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.

Payment Procedure

If you have Insurance: 20% co-pay will be expected at the beginning of treatment. We will file with your insurance whether we participate with them or not. After insurance payment, if there is still a balance, we will bill you. The person responsible for the account will assume all costs that insurance does not cover.

If you do not have insurance, **payment is expected at time of treatment.**

If for any reason treatment is not completed, you will be responsible for only that portion of treatment which is completed.

A charge may be made for additional appointments resulting from the failure of the patient to keep appointments. I understand that if payment is not made when the account is due there will be a finance charge of 1 ½% per month (18% APR) and the account may be turned over for collection. I will be responsible for any and all costs associated with the collection procedure, including but not limited to billing costs, collection fees, lawyers' fees, and court costs.

Privacy Policy

I have been made aware of this offices' Privacy Policy and have been offered a copy of such policy.

BY SIGNING BELOW, I AGREE:

1. **I UNDERSTAND THE ABOVE STATEMENTS IN THE CONSENT FORM AND HEREBY GIVE MY CONSENT TO THE PERFORMANCE OF ENDODONTIC THERAPY/SURGICAL ENDODONTICS. I FURTHER GIVE MY CONSENT FOR THE ADMINISTRATION OF MEDICATIONS, ANESTHETICS, DRUGS AND SERVICES DEEMED NECESSARY TO TREAT MY ENDODONTIC PROBLEM, UNDERSTANDING THAT RISKS ARE INVOLVED. I CONSENT TO REQUESTING INFORMATION FROM THE VIRGINIA PRESCRIPTION DRUG MONITORING PROGRAM DATA CENTER.**

2. **I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO MY DENTIST AND/OR TO MY INSURANCE COMPANY THE COMPLETE DENTAL RECORDS IN YOUR POSSESSION CONCERNING MY TREATMENT IN THIS OFFICE.**

3. **I UNDERSTAND THE PAYMENT PROCEDURE AND WILL BE RESPONSIBLE FOR THE COSTS INVOLVED IN TREATMENT.**

4. **I UNDERSTAND AND HAVE BEEN OFFERED THE PRIVACY POLICY OF THIS OFFICE.**

_____ _____

Signature of patient or legal designate Date