Westchester Endodontic Care

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www.westchesterendodonticcare.com

Salina W. Wu, DDS., PLLC.
Practice Limited to Endodontics

ABOUT YOU

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. Date: _____

Name: _____
(Last) (First) (MI)

I prefer to be called: _____

❑ Male ❑ Female

Birthdate: _____/_____/_____ Age: _____

Social Security No. _____

Home Address: _____
City State Zip

_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Home Phone: (_____)_____ Cell: (_____)_____

Work: (_____)_____ Ext.: _____

Email address: _____

Whom may we thank for referring you? _____

Other family members seen by us:

_____

Previous/ Present Dentist: _____

Emergency Contact: _____

PRIMARY INSURANCE

Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone: (_____)_____

Group # (Plan, Local or Policy #): _____

Insured Name: _____ Relation:_____

Insured Birthdate: _____/_____/_____ SS#: _____

Insured Employer: _____

Employer's Address: _____

_____

SECONDARY INSURANCE

Dental Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____

Insurance Co. Phone: (_____)_____

Group # (Plan, Local or Policy #): _____

Insured Name: _____ Relation:_____

Insured Birthdate: _____/_____/_____ SS#: _____

Insured Employer: _____

Employer's Address: _____

_____

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Our office is HIPAA Compliant and is comitted to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

_____

Signature Date

CONTINUED ON PAGE 2

MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician'sName: _____

Phone: (_____)_____

Do you require antibiotics before treatment? ❑ Yes ❑ No

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Are you taking any prescription/ over-the-counter drugs? ❑ Yes ❑ No

Please list each one: _____

Have you ever taken IV or Oral Bisphosphonate Related Drug? ❑Yes ❑No

If yes, when? _____

For Women:

Are you pregnant? ❑ Yes ❑ No Week #: _____

Are you nursing? ❑ Yes ❑ No

Have you ever had any of the following disease or medical problems

❑Yes ❑No	Abnormal Bleeding	❑Yes ❑No	Hepatitis
❑Yes ❑No	AIDS	❑Yes ❑No	Herpes/ Fever Blisters
❑Yes ❑No	Alcohol/ Drug Abuse	❑Yes ❑No	High Blood Pressure
❑Yes ❑No	Anemia	❑Yes ❑No	HIV
❑Yes ❑No	Arthritis	❑Yes ❑No	Kidney Problems
❑Yes ❑No	Artificial Bones/Joints/Valves	❑Yes ❑No	Liver Disease
❑Yes ❑No	Asthma	❑Yes ❑No	Low Blood Pressure
❑Yes ❑No	Blood Transfusion	❑Yes ❑No	Mitral Valve Prolapse
❑Yes ❑No	Cancer/ Chemotherapy	❑Yes ❑No	Pacemaker
❑Yes ❑No	Colitis	❑Yes ❑No	Psychiatric Problems
❑Yes ❑No	Congenital Heart Defect	❑Yes ❑No	Radiation Treatment
❑Yes ❑No	Diabetes	❑Yes ❑No	Rheumatic/ Scarlet Fever
❑Yes ❑No	Difficulty Breathing	❑Yes ❑No	Seizures
❑Yes ❑No	Emphysema	❑Yes ❑No	Shingles
❑Yes ❑No	Epilepsy	❑Yes ❑No	Sickle Cell Disease/ Traits
❑Yes ❑No	Fainting Spells	❑Yes ❑No	Sinus Problems
❑Yes ❑No	Frequent Headaches	❑Yes ❑No	Stroke
❑Yes ❑No	Glaucoma	❑Yes ❑No	Thyroid Problems
❑Yes ❑No	Hay Fever	❑Yes ❑No	TMJ Problems
❑Yes ❑No	Heart Attack/ Surgery	❑Yes ❑No	Tuberculosis (TB)
❑Yes ❑No	Heart Murmur	❑Yes ❑No	Ulcers
❑Yes ❑No	Hemophilia	❑Yes ❑No	Venereal Disease
❑Yes ❑No	Covid	❑Yes ❑No	Covid Vaccine

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

_____

_____

Are you Allergic to any of the following

❑Yes ❑No	Aspirin/ NASID	❑Yes ❑No	Latex
❑Yes ❑No	Codeine	❑Yes ❑No	Penicillin
❑Yes ❑No	Dental Anesthetics	❑Yes ❑No	Tetracyclin
❑Yes ❑No	Erythromycin	❑Yes ❑No	Other
❑Yes ❑No	Clindamycin		

Please list any other drugs/ materials that you are allergic to:

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

_____

Signature Date

OFFICE USE ONLY

I verbally reviewed the medical/ dental information with the patient names herein.

Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____

_____

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Notice of Privacy Policy

In accordance with federal legislation, I have read and received notice of the privacy policy and understand I do not have to give written permission for these uses of my protected information. I have the right to inspect and copy protected information, to receive confidential communications regarding protected information, to complain if I believe my privacy rights have been violated and to receive a copy of this Notice of Privacy Policy upon request.

_____

Signature Date

MEDICAL HISTORY UPDATE

Has there been any change in your health status since your last visit? ❑Yes ❑No

If yes, please explain _____

_____

_____

Patient Signature Date

_____

Dentist Signature Date

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Reasons for Treatment

Endodontic (root canal) therapy is accomplished in an effort to save a tooth which otherwise would require extraction. Treatment is done by standard root canal therapy, or when necessary, endodontic surgery.

Other Treatment Choices

These include no treatment at all, waiting for more definitive symptoms to develop, and tooth extraction. The risks involved in these choices may include pain, infection, swelling loss of teeth, and spread of infection to other areas.

Risks Specific to Endodontic Therapy

Those risks include the possibility of instruments broken within the root canals, perforation/s (extra openings) of the crown or root of the tooth; damage to bridges, existing fillings, crowns, fracture of porcelain, loss of tooth structure in obtaining access to the canals, and cracked teeth. During treatment complications may be discovered which make treatment impossible, or which may require endodontic surgery. These complications may include: blocked canals due to previous fillings or prior root canal treatment, natural calcification/s, broken instruments, curved roots, periodontal disease (gum disease), splits or fractures of the teeth and reabsorption.

Other Risks of Treatment

Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections. These complications include: swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, which is transient but on rare occasions may be permanent, reaction to injections, changes in occlusion (the bite), jaw muscle cramps and spasms, Temporomandibular joint (TMJ) difficulty or injury to the jaw and supporting structures. Preexisting problems with (TMJ) jaw joint may be aggravated or worsened as a result of treatment, loosening of teeth, referred pain to the ear, neck and head, nausea, vomiting, allergic reactions, delayed healing, sinus perforations and treatment failure.

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 devise until recovered from their effects.

Consent

I, the undersigned, being the patient (parent or guardian of minor patient) consent to the performing of procedures deemed 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 referring and/or regular dentist for a permanent restoration of the tooth involved. This restoration may be a crown (cap), jacket, only or silver 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 retreatment, surgery or even extraction.

Name of Patient (Print) _____

Patient/Guardian (Signature) _____

Witnessed By _____ Date _____

CONSENT FOR LOCAL ANESTHETIC INJECTIONS

I, (print name)_____ , hereby authorize

Dentist/Hygienist/Other (print name) _____ to perform a local

anesthetic injection(s).

I understand, and it has been explained to me, that there are some risks in the administration of local anesthetics. Most risks are related to the position of the nerves under the tissue at the site of the injection which can not be determined prior to the administration of the anesthetic agent. Although the risks seldom occur they might include loss of, or disturbed sensation of the tongue and lip on the side of the injection. If this occurs it is often temporary, and normal sensation usually returns in several days. However, in very rare cases the loss of sensation may extend for a longer period and may become permanent. In addition, injecting a foreign substance into the body such as an anesthetic agent, may result in an allergic reaction. Allergic reactions to these agents are rare, but may take place.

I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions following the injection(s), I agree to report them to the office as soon as possible.

I have been told that the success of my dental treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions, taking prescribed medication and reporting to the office any change in my health status.

I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

I have discussed all of the above with the doctor, and have had all of my questions answered.

_____ _____

Patient's Signature If a Minor, Signature of Parent Or Guardian

_____ _____

Witness Signature Dentist/Hygienist/Other Signature

_____

Date