REGISTRATION

MR. ☐ MRS. ☐
MS. ☐ Dr. ☐ NAME _____ DATE _____ DATE OF BIRTH _____
ADDRESS _____ CITY _____ ZIP _____ HOME PHONE _____ OFFICE _____
EMPLOYER _____ OCCUPATION _____ HOW LONG? _____
NAME OF SPOUSE _____ REFERRED BY _____

MEDICAL HISTORY

ARE YOU IN GOOD HEALTH? _____ ARE YOU PRESENTLY UNDER THE CARE OF A PHYSICIAN? _____
IF YES, PLEASE EXPLAIN _____
PHYSICIAN'S NAME _____ AND PHONE NUMBER _____
ARE YOU TAKING ANY KIND OF MEDICATION (PRESCRIBED OR NOT PRESCRIBED) AT THIS TIME? _____ IF YES, PLEASE
LIST MEDICATION(S) AND EXPLAIN _____

PLEASE MARK ILLNESSES YOU HAVE EVER HAD:

☐ ALCOHOLISM	☐ BLOOD DISEASE	☐ HEART DISEASE	☐ MIGRAINE	☐ HEART MURMUR
☐ ALLERGIES	BLOOD PRESSURE	☐ INFEC. HEPATITIS	☐ MITRALVALE	☐ RHEUMATIC FEVER
☐ ANEMIA	☐ HIGH ☐ LOW	☐ KIDNEY ☐ LIVER	PROLAPSE	☐ SINUSITIS
☐ ASTHMA	☐ DIABETES	☐ MENTAL DISORDER	☐ RESPIRATORY	☐ ULCERS ☐ HIV POS.
				OTHER: _____

HAVE YOU EVER HAD TROUBLE WITH PROLONGED BLEEDING AFTER SURGERY? _____
HAVE YOU RECEIVED ANY OF THE FOLLOWING? ☐ HEART PACE MAKER ☐ DONOR ORGANS ☐ ARTIFICIAL HEART VALVES ☐ JOINT IMPLANTS
HAVE YOU EVER HAD AN UNUSUAL REACTION TO ANY OF THE FOLLOWING? ☐ PENICILLIN ☐ LOCAL ANESTHETICS ☐ ASPIRIN ☐ CODEINE,
OTHER _____
IS THERE ANY OTHER INFORMATION THAT SHOULD BE KNOWN ABOUT YOUR HEALTH? _____
WOMEN; ARE YOU PREGNANT? _____ WHAT WEEK? _____ HAVE YOU EVER HAD ENDODONTIC (ROOT CANAL) TREATMENT? _____

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5x8 / Blue card. 3/6/08

BUSINESS POLICY

The undersigned acknowledges full financial responsibility for services rendered at this office and agrees to pay in full at or before completion. A finance charge of 1 1/2 % per month (annual percentage rate 18%) of the unpaid balance will be added monthly. Should collection become necessary, the responsible party agrees to pay a collection fee of 40% and all legal fees of collection, with or without suit, including attorney fees and court costs.

Person responsible for account _____ Social Security No. _____

INFORMED CONSENT (RCT.)

- I hereby authorize Dr. Johnson with the assistance of his employees to treat the condition that may be decided upon to be necessary or advisable in the opinion of the doctor. I understand that root canal treatment includes possible inherent risks such as, but not limited to the following, including the understanding that no promises or guarantees of results have been made nor expected:

1. The teeth treated may remain tender or even quite painful for a period of time, both during and after completion of treatment.
2. There is a possibility of numbness occurring and/or persisting in the tongue, lips, teeth, jaws and/or facial tissues which may be a result of the anesthetic administration or from treatment procedures. This numbness is usually temporary, but, rarely, could be permanent.
3. A crown (cap) may be damaged or destroyed during rubber dam application access preparation, or other procedures as part of endodontic therapy.
4. There exists the possibility of instrument separation (breakage) inside the tooth which may or may not be detected at the time of treatment.
5. I understand that only the root canal treatment, or treatment associated with this specialty is to be performed at this office. The permanent outside restoration (filling, inlay, crown etc.) will be done by my regular dentist.
6. Once treatment is begun, it is absolutely necessary that the root canal treatment must be completed. I understand I have the option to choose no treatment at all, and being aware that a tooth with a compromised pulp (nerve) has the potential to affect my health. I also understand I have the option to choose to have the tooth or teeth in question removed. Also being aware that it is then recommended to have the area replaced with an artificial prostheses.
7. I further acknowledge that many factors influence success of root canal treatment, and that although treatment is successful in the vast majority of teeth treated, the possibility of failure does exist, which may result in additional treatment, and in some instances the removal of the tooth.

- I have read and understand all sections of this form and have been given the opportunity to ask questions and have received answers to my satisfaction. I also understand the fees for this service and agree to all things herein.

Signed _____ Date _____

SP-4341

BUSINESS POLICY

The undersigned acknowledges full financial responsibility for services rendered at this office, and agrees to pay in full at or before completion. If collection is made by suit or otherwise, I agree to pay all collection costs including reasonable attorney's fees.

Person responsible for account _____ Social Security No. _____

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