



EAST COUNTY
ENDODONTICS

Brian E. Hornberger, D.D.S., M.S

Specializing in Endodontics

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www.eastcountyendo.com

Patient Information

Today's Date _____

Name _____ Male/Female Home # (____) _____ Cell # (____) _____

Address _____ City & Zip _____ Date of Birth _____

Employer _____ Address _____ Phone# _____

Referring Dental Office _____ SSN # _____ Kaiser # _____

Spouse/Parent Information

Spouse/Parent's Name _____ Soc. Sec.# _____ Date of Birth _____

Spouse/Parent's Employer _____ Phone # _____

Person to Contact in Case of an Emergency _____ Phone # _____

If Student, Name of School _____ Full Time _____ Part Time _____

Patient Medical History (please circle yes or no)

Are you under any medical treatment at this time? Yes No

Within the past 5 years have you been hospitalized for any surgical operation or serious illness?

If yes explain _____

Are you currently taking any medication? Yes No

If yes please list _____

Do you use controlled substances? Yes No Do you use tobacco? Yes No

Have you ever taken phen-phen? Yes No Do you take insulin? Yes No

Do you take a blood thinning medication? Yes No

Are you allergic to any of the following? (please circle yes or no)

Latex Rubber Yes No Local Anesthetic Yes No Penicillin or other antibiotics Yes No

Sulfa Drugs Yes No Barbiturates Yes No Sedatives Yes No

Iodine Yes No Aspirin/Ibuprofen Yes No Metals Yes No

Women Only: (please circle yes or no)

Are you or might you be pregnant? Yes No Are you nursing? Yes No

Are you taking oral contraceptives? Yes No

Do you have history of the following? (please circle yes or no)

Heart Attack	Yes / No	Hepatitis	Yes / No	Thyroid Problems	Yes / No
Heart Murmur	Yes / No	Jaundice	Yes / No	Radiation Therapy	Yes / No
Mitral Valve Prolapse	Yes / No	Asthma	Yes / No	Tuberculosis	Yes / No
Sexually Transmitted Disease	Yes / No	Anemia	Yes / No	Respiratory Problems	Yes / No
Heart Disease	Yes / No	Angina	Yes / No	Fainting Seizures	Yes / No
Cardiac Pacemaker	Yes / No	Emphysema	Yes / No	Epilepsy/Convulsions	Yes / No
Joint Replacement/Implant	Yes / No	Cancer	Yes / No	Kidney Disease	Yes / No
Diabetes	Yes / No	Stroke	Yes / No	Stomach Ulcers	Yes / No
AIDS/HIV	Yes / No	Liver Disease	Yes / No	Blood Pressure	High/Low
Other	Yes / No				

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. I understand that providing false information can be dangerous to my health. I authorize the dentist to release information including diagnosis and records of treatment rendered to me or my dependent to a third party payee and/or health practitioners.

I authorize and request my insurance company to pay directly to Dr. Hornberger/East County Endodontics.

I understand that the insurance information provided to me is an estimate only and not a guarantee of payment.

I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Method of Payment

Patient Co-payment must be paid in full at the time of treatment. How will you be paying today? (please circle one)

Cash Check Visa MC Discover American Express

X _____
Signature of patient (or parent if minor)

X _____
Signature of Doctor



CONSENT FOR TREATMENT

Root canal treatment, also known as "endodontic treatment," is a procedure that attempts to retain a tooth or teeth which otherwise might need to be extracted. I hereby authorize the Doctor and his assistants to perform necessary procedures which have been described to me. I further request and authorize them to do whatever they deem necessary as a result of unforeseen circumstances.

***PLEASE DO NOT BE ALARMED BY THE FOLLOWING INFORMATION. MOST COMPLICATIONS ARE QUITE RARE.**

I, the undersigned, have been informed that I require an endodontic procedure and that I fully understand the following:

- > Failure to follow this recommendation may result in: loss of the tooth, bone destruction due to an abscess, pain, or possible systemic (affecting whole body) infection.
- > Root canal treatment may not relieve my symptoms, and that treatment can fail during or after completion of treatment, and that it may fail for unexplainable reasons. If the root canal fails it may require retreatment, surgery, or extraction. Root canal therapy is not a guarantee.
- > Complication of root canal therapy and local anesthesia may include: swelling, pain, trismus (restricted jaw opening), infection, bleeding, sinus involvement and numbness or tingling of the lip, gum or tongue, which rarely is protracted and even more rarely permanent.
- > During treatment, complications may be discovered which make treatment impossible, or which may require dental surgery. These complications may include: instruments broken within the root canals which may be incorporated into the filling material, perforations of the crown or root of the tooth, loss of tooth structure in gaining access to canals, blocked canals due to fillings, natural calcification, or splits/fractures of the root.
- > About 10% of root canal treated teeth are lost due to periodontal disease (gum disease/pyorrhea,) splits or fractures of the roots.
- > When making an access (opening) through an existing crown or placing a rubber dam clamp, possible damage can occur and a new crown may be necessary after endodontic therapy. You may also experience loosening or loss of dental restorations and occlusion (bite) changes.
- > Infection may occur or an existing infection may worsen in the tooth being treated or the area around it, and I may need antibiotics and/or other procedures to treat the infection. There are risks involved in administration of anesthetics, analgesics (pain medication) and antibiotics. I will inform the doctor of any previous side effects or allergies.
- > Successful completion does not prevent future decay or fracture. To protect your tooth from decaying or fracturing, you must return to your dentist for a permanent filling or crown within 6 weeks after the completion of the root canal therapy. Failure to follow up with the final restoration in a timely manner may result in failure of the root canal treatment and could reduce its prognosis. A fee will be charged if retreatment and apical surgery is required due to lack of final restoration.

I have discussed my treatment with the Doctor, and have been given the opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, and the risks of the recommended treatment.

Patient/Guardian Signature

Date



Date _____

I am aware of and understand the HIPAA Privacy Act (Health Information Portability & Accountability Act.)

Print Patient's Name

Patient's Signature

For Office Use Only

We have attempted to obtain acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be retained for the following reasons:

- Individual refused to sign
- Communication barriers prohibited the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify) _____

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