SILVAGGIO ENDODONTICS
EASTON ENDODONTIC ASSOCIATES

PLEASE ANSWER **EACH AND EVERY QUESTION** ON **BOTH PAGES** OF THIS FORM. It is **IMPORTANT** to include all information we are requesting, especially MEDICATIONS, VITAMINS and SUPPLEMENTS you may be taking at this time.

Date:_____

Patient Name:_____

Address:_____

City:_____ State:_____ ZIP:_____

Home Phone:_____

Work Phone:_____

Cell Phone:_____

Sex:_____ Marital Status:_____ Age:_____

Birth Date:_____ Soc Sec #_____

Occupation:_____

Employer:_____

Pharmacy:_____ Phone:_____
Pharmacy Address:_____

Have you ever been treated by our doctors? Yes_____ No_____

Who **referred you to this practice**? Should they receive our report?

_____ Yes_____ No_____

Who is your **general dentist**? Should they receive our report?

_____ Yes_____ No_____

Are you seeing **any other dental professionals** to which you would like a report sent for this and/or any other visits?
Yes_____ No_____ If yes, who?_____

PLEASE READ THE FOLLOWING CAREFULLY:
The information contained on this form is correct, to the best of my knowledge. I agree to be responsible for all fees related to my visits here, including any returned check charges, as displayed. I allow release of all of my information to my dentist/doctors, as required by them.

To the extent permitted by law, I consent to your use and disclosure of my protested health information to carry out payment activities in connection with all insurance claims.

Signature:_____ Date:_____
(If the patient is a minor, parent/guardian must sign)

IF PATIENT IS A MINOR UNDER 18 YEARS OF AGE, PARENT/GUARDIAN MUST FILL IN THEIR

Name:_____

Soc. Sec. No.:_____ Birth Date:_____

Address / Phone, if different from Minor's:_____

PLEASE FILL IN EACH SECTION WITH YOUR DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

DENTAL Insurance Co.:
_____

EMPLOYER the benefits are through:_____

ID #/ Soc. Sec. #: _____

IF THE PATIENT **IS NOT** THE SUBSCRIBER, PLEASE FILL IN:

Subscriber Name:_____

Relationship to the Patient:_____

Address if different from the Patient's:_____

Subscriber ID #/ Soc. Sec. #:_____

Subscriber Date of Birth:_____

SECONDARY DENTAL INSURANCE

DENTAL Insurance Co.:
_____

EMPLOYER the benefits are through:_____

ID #/ Soc. Sec. #: _____

IF THE PATIENT **IS NOT** THE SUBSCRIBER, PLEASE FILL IN:

Subscriber Name:_____

Relationship to the Patient:_____

Address if different from the Patient's:_____

Subscriber ID #/ Soc. Sec. #:_____

Subscriber Date of Birth:_____

PLEASE CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE OR HAVE HAD IN THE PAST:

Heart Trouble Heart Murmur Mitral Valve Prolapse

Rheumatic Fever Angina High Blood Pressure

Epilepsy Asthma Paget's Disease Low Blood Pressure

Stroke / TIA Multiple Myeloma Congenital Heart Disease

Diabetes Osteogenesis Imperfecta Thyroid Disease

Tuberculosis Arthritis Glaucoma Anemia

Lung Disease Radiation Treatment Convulsion

Herpes Hepatitis A B or C Kidney Disorder

Psychiatric Treatment Ulcer Migraine MS

Sinus Conditions Fainting Spells Venereal Disease

Osteoporosis Blood Disorders Other:_____

Cancer-Type:_____

PLEASE CIRCLE ANY OF THE FOLLOWING TO WHICH YOU ARE ALLERGIC OR HAVE HAD AN UNUSUAL REACTION TO:

Latex Epinephrine Novocaine / Xylocaine Barbiturates

Vancomycin Penicillin / Amoxicillin / Ampicillin / Augmentin

Clarithromycin (Biaxin) / Erythromycin / Azithromax, Azithromycin, Zithromax (Z-PAK)

Metronidazole (Flagyl) Moxifloxacin (Avelox)

Sulfa Drugs / Bactrim Clindamycin (Cleocin) / Lincomycin

Tetracycline / Doxycycline /Minocycline (Minocin)

Cephalexin (Keflex) / Cefaclor (Ceclor) / Cefuroxime (Ceftin)

Ciprofloxacin (Cipro) Valium Sedatives Steroids

Advil / Motrin / Ibuprofen Aleve / Naproxen Aspirin Codeine

Acetaminophen (Tylenol) Tramadol (Ultram) Vicodin

Other:_____

GENERAL HEALTH

Excellent Good Fair Poor

Are you under the care of a physician at this time?_____

If yes, explain:_____

Physician Name:_____

Do you have artificial joints? YES_____ NO_____

Have you been instructed to pre-medicate with large dose antibiotics one hour prior to your dental appointments? YES _____ NO_____ ** If Yes, did you take them?_____

LIST THE NAMES OF ALL

Prescribed and Non-Prescribed medications, vitamins, supplements, recreational drugs, etc. that you are taking today:

_____

_____

_____

_____

_____

Are you taking or have you taken **in the past 10 years** any **Bisphosphonates?** (EX: Actonel, Aldronate, Aredia, Boniva, Didronel, Fosamax, Reclast, Skellid, Zometa)

YES ____ NO____ If YES, which one?_____

Do you have a pacemaker or heart valve prosthesis?

YES_____ NO_____

Have you been hospitalized or had a serious illness in the past five years? YES_____ NO_____

If YES, Explain_____

Have you ever been diagnosed as having **HIV** or **AIDS?**

YES_____ NO_____

Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma?

YES_____ NO_____

Are you pregnant? YES_____ NO_____ If YES, how far along are you? _____

Have you ever undergone endodontic treatment (Root canal therapy or apical surgery)? YES_____ NO_____

What symptoms are you experiencing today?

_____

_____

_____

_____

_____

Is there any other information we should know about your health or teeth?

_____

_____

_____

_____

_____

_____

SILVAGGIO ENDODONTICS EASTON ENDODONTIC ASSOCS

INFORMED CONSENT FOR ENDODONTIC TREATMENT

PA STATE and our INSURANCE CARRIERS STRONGLY RECOMMEND A CONSENT FORM PRIOR TO ENDODONTIC TREATMENT

Before starting endodontic treatment (root canal therapy, retreatment, apicoectomy, etc.), you need to be informed of **all risks** and **alternatives** to endodontic treatment. You are required to sign this consent prior to the initiation of treatment. However, it does **not** commit you to treatment. **This consent serves to acknowledge that you have been informed and understand the following.**

Endodontic Treatment is an attempt to retain a tooth, which may otherwise require extraction. It is a process involving removal of tissues in the center of the tooth, the canals within the root(s), and the sealing of the space that is created during the process of removal and cleansing of the root canal system. The root canal treatment may fail, if proper restoration of the tooth is not completed after the root canal treatment is done. That restoration is a separate and distinct procedure with an additional fee. **Endodontic Surgery, most commonly apicoectomy,** involves an incision into the gingival tissues (gums). The apicoectomy also involves the removal of the root tip of the tooth/teeth and, in some cases, the removal of infected bone tissue.

Although root canal therapy has a high degree of success, it cannot be guaranteed. The doctor will exact his professional training to achieve success and avoid or minimize complications listed below. Initial root canal therapy success rate can be as high as 90%. Occasionally, a tooth which has previously had root canal therapy may require retreatment, microsurgery, or extraction. Retreatment and surgical success rates are approximately 70%.

The alternatives to endodontic treatment include: no treatment, waiting for more definitive development of symptoms, and extraction of the tooth. The risks of no treatment include, but are not limited to, infection, swelling, cyst formation, pain, loss of the tooth/teeth, and/or systemic disease. Risks of endodontic treatment are of two kinds; those **risks associated with general dental procedures**, as in any dental office, and those **risks specific to endodontic treatment**, as in this office.

Risks of General Dental Procedures include, but are not limited to: complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections. These complications include pain, infections, swelling, bleeding, sensitivity, numbness, and tingling sensation, temporary or permanent, in the lips, tongue, chin, gums, cheek, and teeth, thrombophlebitis (inflammation to the vein), reaction to injections, including a temporary rapid heartbeat, change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth or restorations in or on teeth, injury to other tissues, referred pain to the ear, neck and head, nausea, vomiting, allergic reactions, itching, bruises, delayed healing, sinus complications, and further surgery. Prescribed medication and drugs may cause drowsiness and lack of awareness and coordination, which may be influenced by the use of alcohol and other drugs. Therefore, it is advisable not to operate any vehicle or hazardous device, or to work for 24 hours, or until recovered from their effects. Antibiotics may interfere with oral contraceptives and caution should be used during antibiotic use.

Risks specific to Endodontic Treatment include, but are not limited to: instruments broken within the root canal(s), perforations (extra openings) of the crown or root of the tooth, damage to bridges, existing fillings, crowns or porcelain veneers, loss of tooth structure in gaining access to canals, fracture of tooth structure, and change in tooth color (becoming darker than adjacent teeth). During treatment, complications may be discovered which make treatment impossible, or may require microsurgery or extraction. These complications may include blocked or obstructed canals resulting from fillings, prior treatment, natural calcification, broken instruments, curved roots, periodontal disease (gum disease), and cracks or fractures of the teeth. **If you are scheduled for surgery,** the risks specific to it involve an incision into the gingival tissue (gums). Any incision into the gums carries inherent risks. Apicoectomy surgical procedure may also involve the removal of infected bone tissue and root tip of the tooth/teeth.
Risks specific to Endodontic Surgery include, but are not limited to: swelling, scar formation from the incision, infection, recession of the gum line, bleeding, post-operative pain, bruising of the gums and face, temporary or permanent numbness or tingling of the lip, chin, tongue or other areas, damage to adjacent teeth, and perforation into the sinuses.

I HAVE READ AND UNDERSTAND THE ABOVE RISKS AND ALTERNATIVES TO ENDODONTIC SERVICES AND HAVE DISCUSSED THEM WITH MY ENDODONTIST. BY MY SIGNATURE BELOW, I CONSENT TO THE ENDODONTIC EVALUATION AND/OR TREATMENT REQUIRED.

PATIENT'S SIGNATURE: _____ **DATE:** _____
(Parent/Guardian must sign if patient is a minor)

PRINT NAME PLEASE: _____

ENDODONTIST'S SIGNATURE: _____ **DATE:** _____

If Patient is a Minor, Please Print Their Name: _____
Relationship of Patient to the Adult Signing: _____

Joseph A. Silvaggio, DMD, PC

SILVAGGIO ENDODONTICS **EASTON ENDODONTIC ASSOCS**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Date _____

This acknowledgement of notice and consent authorizes Joseph A. Silvaggio, DMD, PC to use and disclose health information about you and your treatment, payment, and healthcare operations purposes. This practice has a "Notice of Privacy Practices," which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. ***Please ask at the front desk if you desire to read or obtain the full privacy notice.***

I, (print name) _____, am aware of and/or received a copy of this practice's "Notice of Privacy Practices" and authorize them to use and disclose health information for treatment, payment, and healthcare operations purposes consistent with its "Notice of Privacy Practices."

_____

Signature of Patient *(or parent/guardian if patient is a minor)*

_____ _____

Printed Name of Minor Patient **Relationship to Patient**

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Please fill in the **EMERGENCY CONTACT PERSON.** Also fill in **ALL NAMES OF THOSE WITH WHOM WE CAN DISCUSS YOUR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.** It is not necessary to include your dentist/referring dentist, as it is understood that he/she would be included to receive your treatment, payment, or healthcare operations information.

Emergency Contact	Relationship to Patient	Phone Number
Responsible Party	Relationship to Patient	Phone Number
Responsible Party	Relationship to Patient	Phone Number
Responsible Party	Relationship to Patient	Phone Number

AT WHAT TELEPHONE NUMBERS ARE WE ABLE TO CALL YOU OR LEAVE A MESSAGE FOR YOU?

PREFERRED TELEPHONE NUMBER_____ **INDICATE** CELL / WK / HM

2ND PREFERRED NUMBER _____ **INDICATE** CELL / WK / HM

3RD PREFERRED NUMBER _____ **INDICATE** CELL / WK / HM