

MEDICAL HISTORY

Print Name: _____

1. Has there been any change in your general health within the past year? Yes No
Please specify _____
2. Are you under the care of a physician for a current problem? Yes No
Reason _____
3. Have you been hospitalized within the past five years? Yes No
Reason _____
4. Are you taking any medications or drugs? Yes No
Please specify _____
5. Have you received therapy for alcoholism or drug addiction during the past 5 years? Yes No
6. Have you ever had any ALLERGIC OR ADVERSE REACTIONS to anesthetics, antibiotics, latex, iodine or other medications? Yes No
If Yes, please specify _____
7. Have you ever required a blood transfusion? Yes No
Please explain _____
8. Have you ever had surgery and/or radiation for a tumor, growth or other condition? Yes No
9. Have you ever been tested for HIV infection (AIDS)? Yes No
Result of test: Date: _____ Positive Negative
10. Date of last physical exam: _____

Do you have or have you had any of the following (please check):

- | | |
|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart murmur or mitral valve prolapse (MVP) | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Joint replacement (hip, knee, etc.) | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Rheumatic fever or rheumatic heart disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Stomach, ulcers, colitis |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Cardiovascular disease: heart attack, stroke, by-pass | <input type="checkbox"/> Psychiatric treatment |
| <input type="checkbox"/> Prosthetic heart valve | <input type="checkbox"/> Fainting spells or seizures |
| <input type="checkbox"/> Blood disorder (e.g., anemia) | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Hepatitis, jaundice, liver disease | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Temporomandibular joint problems (TMJ) | <input type="checkbox"/> Radiation therapy |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Do you have any disease, condition, or problem not listed above? If so, please specify: _____ |
| <input type="checkbox"/> Are you required to take premeds prior to dental treatment?
If checked, have you taken your pre-meds today? (yes / no) | |

Women:

- Are you pregnant? Yes No
Are you nursing? Yes No
Do you take Birth Control Pills? Yes No
If yes, be advised that if you take antibiotics, an alternate method of birth control must be used.

PERMISSION FOR ROOT CANAL TREATMENT—I the undersigned, consent to the performing of any dental procedure of the tooth which may be decided upon to be necessary or advisable in the opinion of the doctor. I also understand my other option is extraction. I also understand that only the root canal treatment is to be done at the office. The permanent (outside) restoration (filling, inlay, crown, etc) will be completed by my regular dentist.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. **I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents and any amount not covered by my dental insurance.** I acknowledge that I have received a notice of HIPPA privacy practices. *****I agree that if my account is referred to a collection agency or attorney, to pay the fees accrued as well as any other charges that may develop from this action . I understand that the reason I'm providing my Social Security number and Date of Birth below is for that reason.*****

***Responsible party's Name: _____ SS# _____ DOB _____ ***

Signature of Patient* _____ Date _____

(Signature must be by the parent or guardian if patient is under the age of 18.)

Doctor's Comments _____

Vaughn Endodontics

ACKNOWLEDGEMENT NOTICE OF PRIVACY PRACTICE

(If you are unaware of the Hipaa Privacy Act,
please see the displayed form in the reception area)

_____, is aware and understands Hipaa Privacy Act.
(Please Print Patient Name)

(Please Print Appropriate Name(s) Above, if the following is Applicable)
The preceding person(s) have authorization from patient to inquire or discuss patient's financial responsibility or medical treatment. (I.E. spouse, parent of a child over 18, or other authorized agent...)

(Patient's/Parent's Signature) (Date)

*** You May Refuse To Sign This Acknowledgement***

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

Comments: _____

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Aaron Vaughn DDS, MS • Lisa Alvarado DDS

CONSENT FOR ENDODONTIC THERAPY

Please review the following consent form. You will be required to sign this form prior to the initiation of treatment. Your signature does not commit you to any treatment.

I understand the root canal therapy is a procedure involving the removal of a portion of the inside of the tooth and is intended to save the tooth, which may otherwise require extraction. As a specialty practice, this office performs primarily endodontic (root canal) therapy and associated surgery. Although root canal therapy has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery, or even extraction. Following treatment, the tooth may be weakened and subject to fracture. A restoration (filling), crown and/or post and core will be necessary to restore the tooth, and your general dentist will perform these procedures. During endodontic treatment, there is the possibility of instrument separation (breakage) within the root canals, perforations (extra openings), damage to bridges, existing fillings, crowns or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals, and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when the tooth may not be amenable to endodontic treatment at all. Other treatment choices include no treatment, a waiting period for more definitive symptoms to develop, or tooth extraction. Risks involved in those choices might include, but are not limited to, pain, infection, swelling, loss of teeth, and infection to other areas.

I understand that I will have the opportunity to ask questions prior to treatment and at any time thereafter. I fully understand the above statements in this consent form.

Occasionally, medication will be prescribed by the doctor. Medications prescribed for discomfort and/or sedation may cause drowsiness, which can be increased by the use of alcohol or other drugs. We advise that you do not operate a motor vehicle or any hazardous device while taking such medications. In addition, certain medications may cause allergic reactions, such as hives or intestinal discomfort. If any of these problems occur, call the doctor immediately. It is the patient's responsibility to report any changes in his/her medical history to the doctor.

Furthermore, I give my permission to take photos of my procedure for purposes of completing my medical record, patient education or teaching purposes.

Note: All medical records will be kept strictly confidential.

Patient (Print Name) _____

Patient (Signature) _____

Date _____

(If patient is under the age of 18, the signature of a parent or guardian is required.)