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? ☐Yes ☐No
7. Are you ALLERGIC to antibiotics, latex, iodine or other medications? ☐Yes ☐No

   Please specify____
8. Have you ever required a blood transfusion? ☐Yes ☐No
   Please explain____
9. Have you ever had surgery and/or radiation for a tumor, growth or other condition? ☐Yes ☐No
10 Have you ever been tested for HIV infection (AIDS)? ☐Yes ☐No
   Result of test: Date:___________ ☐ Positive ☐ Negative

- ☐ High Blood Pressure
- ☐ Heart murmur or mitral valve prolapse (MVP)
- ☐ Joint replacement (hip, knee, etc.)
- ☐ Rheumatic fever or rheumatic heart disease
- ☐ Congenital heart disease
- ☐ Chest pains
- ☐ Cardiovascular disease: heart attack, stroke, by-pass
- ☐ Prosthetic heart valve
- ☐ Blood disorder (e.g., anemia)
- ☐ Hepatitis, jaundice, liver disease
- ☐ Venereal disease
- ☐ Temporomandibular joint problems (TMJ)
- ☐ Osteoporosis
- ☐ Are you required to take premeds prior to dental treatment?

If you checked yes to premeds, have you taken them today? ☐Yes ☐No

- ☐ Asthma
- ☐ Sinus Trouble
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Stomach, ulcers, colitis
- ☐ Kidney problems
- ☐ Psychiatric treatment
- ☐ Fainting spells or seizures
- ☐ Tuberculosis
- ☐ Epilepsy
- ☐ Cancer
- ☐ Radiation therapy
- ☐ Do you have any disease, condition, or problem not listed above? If so, please specify:

____

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.

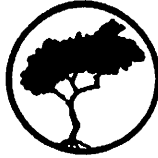
I certify that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners.
Initials: ____

I authorize my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me.
Initials: ____

Any balance regarding this account remains the responsibility of the patient or legal guardian in the case of a minor. I understand that if my account is referred to a collection agency or attorney, I am responsible for any fees accrued, as well as any other charges that may develop from this action.
Initials: ____

Emergency Contact ____________________ Relation to Pt: ______________ Phone # ______________

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



VAUGHN ENDODONTICS

CONSENT FOR ENDODONTIC THERAPY

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. This office specializes in endodontic (root canal) therapy. Although endodontic therapy has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth which has had a root canal may require re-treatment, surgery, or even extraction. Following treatment, the tooth may be weakened and subject to fracture. A restoration (filling) and crown will be necessary to permanently restore the tooth. Your general dentist will provide these procedures. During endodontic treatment, there is the possibility of instrument separation (breakage) within the root canals as well as a possibility of perforations, damage to bridges, existing fillings, crowns or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals, and fractured teeth. There are times when a minor surgical procedure may be indicated or when the tooth may not be amenable to endodontic treatment.

Other treatment options in treating tooth infection include tooth extraction (pulling the tooth) or a waiting period for more definitive symptoms to develop. Risks involved in delay of treatment might include, but are not limited to; pain, infection, swelling, loss of teeth and infection to other areas.

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

All medical records will be kept strictly confidential.

I fully understand the above statements in this consent form.

Patient Signature ___________________ **Date** ______________

Your signature does not commit you to any treatment in this office.

Vaughn Endodontics

ACKNOWLEDGEMENT
NOTICE OF PRIVACY PRACTICE (HIPAA)

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

Summary

This office may use the information you have provided, to communicate with your referring doctor or your other health care providers as needed to manage your health care. We may also use your information to obtain payment for your health care services through insurance or other means. For more details regarding HIPPA please see the additional information provided with this document.

_____________________________is aware and understands HIPAA Privacy Act.
(Please Print Patient Name)

______________________________ has authorization from patient (above) to inquire or discuss patient's financial responsibility
(spouse, parent of a child over 18, or other authorized agent...Only if applicable)

.

________________________ ________________________
(Patient's Signature) *(Date)*

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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