**PATIENT INFORMATION** **Today's Date:**_____/_____/_____ Name of your general dentist: _____

What influenced you to select our office? (circle all that apply) general dentist internet sign Gentlewave sedation friend other

**Patient's Legal Name**: _____ Name Called:_____

Date of Birth: _____/_____/_____ Age: _____ Social Security#: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Home Phone: (___) _____ Work Phone: (____) _____

Cell Phone: (___) _____ E-Mail Address: _____

Emergency contact name: _____ Phone _____ Relationship _____

**Insurance Co**.: _____ Employer: _____

**Policy Holder's Name**: _____ DOB for Policy Holder:_____/_____/_____

Member ID/SS#_____

Insurance benefits are not always guaranteed. I agree to be responsible for any fees for services provided by this office.

Signature of guarantor: _____

**Health Questionnaire / Risk Assessment**

Please provide us as much information as possible about your medical doctors:

Internist or primary care: _____ Phone: _____
Ob/Gyn: _____ Phone: _____
Cardiologist: _____ Phone: _____
Endocrinologist/Diabetes: _____ Phone:_____
Other: _____

**Do you have any allergies/reactions to medications/substances? YES NO Please list:**

_____

Please list all supplements, herbal, over the counter & prescribed medications you are taking: _____
_____
_____

Do you pre-medicate prior to dental appointments with:

- Antibiotics for heart conditions or artificial joints? Y N type/amount:_____
- Antianxiety medication/herbs/supplements for dental anxiety? Y N type/amount:_____

How much anxiety do you have about dental treatment? None Mild Moderate Severe

Would you like to be sedated in our office for dental treatment? **Y N**

**Patient name**:_____ Age _____ Height _____ Weight _____

{Office use only: BP: _____/_____ P:_____ Resp: _____ O2:_____ BMI:_____ }

How long has it been since your last physical with blood work? 6 mo 12 mo 18 mo 24 mo or more

Women: Are you pregnant? **Y N** Do you take birth control pills? **Y N** Are you nursing? **Y N**

**Do you have, or have you ever had any of the following conditions (circle Y (yes) N (no)?**

| | | |
|---|---|---|
| Heart Defects | **Y N** | Month/Year corrected:_____ Not corrected |
| Heart Murmur | **Y N** | Type: _____ |
| Heart Attack | **Y N** | Month/Year:_____ |
| Heart Surgery | **Y N** | Month/Year:_____ bypass, stent, valve, oblation, other? |
| Pacemaker | **Y N** | Month/Year:_____ |
| Angina Pectoris | **Y N** | Date of last episode: _____ |
| Stroke | **Y N** | Month/Year: _____ full or partial recovery |
| High Blood Pressure | **Y N** | What is your normal/usual BP? _____ I don't know |
| Diabetes | **Y N** | Year diagnosed: _____ **Type:** 1 or 2 |
| Liver disease | **Y N** | Type: _____ |
| Hepatitis | **Y N** | Year diagnosed: _____ Type: A B or C full or partial recovery |
| Bleeding/blood dis. | **Y N** | Type: _____ |
| Epilepsy or seizures | **Y N** | Date of last episode:_____ |
| Fainting or dizziness | **Y N** | Date of last episode: _____ |
| Cancer | **Y N** | Type: _____ |
| Radiation therapy | **Y N** | Month/Year: _____ |
| Chemotherapy | **Y N** | Month/Year:_____ |
| Autoimmune disease | **Y N** | Type: _____ |
| HIV | **Y N** | Year diagnosed: _____ |
| Tuberculosis | **Y N** | Year diagnosed: _____ |
| Osteoporosis | **Y N** | Month/year:_____ Treated with bisphosphonates: _____ No bisphosphonates |
| Joint replacement | **Y N** | Month/Year: _____ Type: _____ |
| STD (sexually transmitted disease) | **Y N** | Year diagnosed: _____ Type: _____ |
| Psychatric Condition | **Y N** | Year diagnosed: _____ Taking medication? Y N Type: _____ |
| Alzheimers/Dementia | **Y N** | Year diagnosed: _____ |
| Drug/Alcohol Addiction | **Y N** | Date last use: _____ Type: _____ Narcotics? _____ |
| Thyroid Disease | **Y N** | |
| Stomach ulcers | **Y N** | |
| Kidney disease | **Y N** | |
| Lung disease | **Y N** | |
| Emphysema or COPD | **Y N** | |
| Asthma | **Y N** | |

Any other condition not listed? _____

I certify the above information is true and accurate. Thank you!

Patient/guardian signature: _____ Date: _____

Reviewed by Doctor: _____ Date: _____

**Michael J. Binns DDS, PC**

# Consent Form for Endodontic (Root Canal) Treatment

PATIENT NAME: _____ Tooth #_____

I understand Dr. Binns is a general dentist who limits his practice to root canal treatment. I am satisfied with his qualifications and do not desire treatment by an endodontist.

_____ **Patient initials**

Root canal treatment is performed to save a tooth that might otherwise need to be removed. Root canal treatment is successful most of the time, but this cannot be guaranteed. Dr. Binns is pleased to announce that we are now offering the GentleWave Procedure. This procedure offers superior cleaning and disinfection of your root canal system using a minimally invasive protocol that allows for maximum preservation of tooth structure, less post-operative discomfort and faster healing times. At times a tooth that has had root canal therapy will require additional treatments to save the tooth such as surgery to remove infection around the root tip, surgery to increase the length of a badly broken down tooth, filling or post and crown. All recommended treatments must be completed to insure the best chance of success. Failure to do so will ultimately result in failure and probable loss of the tooth. I understand the above explanation and have had all of my questions answered to my satisfaction.

_____ **Patient initials**

There are certain risks associated with dental treatments. Complications may arise from use of dental instruments, chemicals, drugs and anesthetics (novacaine, lidocaine, etc). The most common complications that can arise with root canal treatment are swelling, sensitivity, pain, bleeding, infection, delayed healing, reactions to medications including dizziness, drowsiness, nausea, vomiting, rash, and allergic reactions. Nerve damage can also occur resulting in prolonged or permanent tingling or numbness in the lip, tongue, cheek, gum or teeth. Changes can occur in the way your teeth fit together resulting in loosening of teeth, jaw muscle cramps, joint difficulties, and pain in the teeth, ear, neck and head. Damage to the tooth, existing restorations, adjacent teeth & soft tissue can occur due to failure of dental instruments and other events such as broken/irretrievable files, chemical burns and severe tissue reactions & sinus perforation. All of these events can result in swelling, pain, infection, the need for additional treatment, and/or treatment failure and tooth loss. The most severe infections and reactions can be life threatening resulting in hospitalization. These most severe complications are possible, but rare. I understand the above explanation and have had all my questions answered.

_____ **Patient initials**

Other treatment choices include having no treatment or removing the tooth. Risks of these choices include but are not limited to pain, infection, swelling, tooth loss and infection to other areas of the body. In spite of the possible complications and risks, I desire the recommended treatment. I acknowledge that no guarantees have been made to me concerning the results of this treatment. I have had the opportunity to ask questions and receive satisfactory explanations for all of my questions about my condition, contemplated and alternative treatments, and the risks and potential complications associated with each of the contemplated and alternative treatments prior to signing this form.

_____ **Patient initials**

I hereby authorize the doctor and staff to perform all recommended and necessary treatment for me. I also authorize the use of radiographs, photographs, or videotapes of my case for use in presentations or publications by the doctor. I also give permission for Dr. Binns and his staff to discuss my drug and medical history with my personal doctors, dentists and pharmacists to discuss my complete drug and medical history and understand that narcotic prescriptions will not be provided if abuse is suspected.

_____ **Patient initials**

_____ _____

Patient or Guardian Signature Date

_____ _____

Reviewed by Dentist Date

Michael J. Binns DDS, PC

**Statement of Patient Financial Responsibility**

All account balances are due in full at the time of treatment unless other financial arrangements have been made in advance.

Our office will bill your dental insurance company on your behalf. If insurance does not pay after a maximum of two submissions and within the first 30 days after treatment then you will be responsible for the balance. If insurance pays the claim in full then any credit balance will be refunded to you in the form of a check within 30 days. If insurance pays less than expected then you will be responsible for the remaining balance within 30 days. Ultimately you are responsible for payment of all fees for services provided in our office.

A **major credit card** is required at the time of treatment to guarantee payment for all services. After the account has been paid in full the credit card information will be deleted from our records.

**I understand and authorize my card to be charged after 30 days if there is still a balance on my account.**

You will receive a bill from our office after **30 days** requesting prompt payment in full if your insurance company denies or delays payment for any reason. This will allow you the opportunity to pay the balance prior to your card being charged.

**I understand that I am ultimately responsible for all charges associated with my account**
and that if I fail to pay any amount due I will also be responsible for all collection fees, court costs, attorney and representative costs, accrued interest, and any other charges incurred in the delay or collection of any balance due.

I have read the above statements and accept the financial responsibility for the dental treatment for myself and any other individual for whom I am guarantor or guardian.

_____ _____

**Patient Printed Name** **Date**

_____ _____

**Patient Signature** **Office Staff signature**