



Practice Limited to Endodontics • www.montshireendo.com  
367 Route 120 Suite B3 • Lebanon • New Hampshire • 03766  
Office: 603.643.6100 Fax: 603.643.9966  
2418 Airport Road, Suite2 • Barre • Vermont • 05641  
Office: 802.371.0014 Fax: 802.229.5477

### Welcome to Our Office

We will try to do everything possible to care for your dental health. This CONFIDENTIAL acquaintance form will help us to serve you better.

#### General Information

Ms.    Mrs.    Mr.    Dr.    Jr.    Sr.

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Preferred Pronouns:       She/Her       He/Him       They/Them

Social Security Number: \_\_\_\_\_

Address

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

#### INSURANCE INFORMATION:

Subscriber ID: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Spouse/Parent (if minor): \_\_\_\_\_ General Dentist: \_\_\_\_\_

#### Primary Complaint

Do you presently have a toothache?       Yes       No

Is any part of your mouth sensitive to the following?

Cold    Heat    Bite    Touch    Unprovoked pain

Have you ever had root canal treatment?       Yes       No

## Health Information

Physician's name \_\_\_\_\_ Phone: \_\_\_\_\_

Are you presently under a physician's care?  Yes  No

If yes, please explain \_\_\_\_\_

Have you been hospitalized or had a serious illness in the last 2 years?  Yes  No

If yes, please explain \_\_\_\_\_

Do you take aspirin daily?  Yes  No

Have you ever been treated for alcoholism or drug addiction?  Yes  No

Do you have or have you ever had any of the following:

	Yes	No		Yes	No
Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Date _____		
Date _____			Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease/Angina	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Valve (Heart)	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Depression	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Bruising	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Control method?	<input type="checkbox"/> Diet	<input type="checkbox"/> Med
Asthma/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	HIV positive or AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis {TB}	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>	Women Only:	Yes	No
Date: _____			Could you be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	If so, how many months?	_____	
Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Taking birth control pill?	<input type="checkbox"/>	<input type="checkbox"/>
Radiation	<input type="checkbox"/>	<input type="checkbox"/>	(Antibiotics may interfere with effectiveness of oral contraceptives.)		
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>			

Have you ever had an adverse reaction to local anesthetics?  Yes  No

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

I, the undersigned (patient or legally responsible party), consent to the dental treatment decided upon to be necessary by the Dentist and myself. I further authorize the taking of radiographs and/or other diagnostic measures appropriate for a thorough evaluation. I understand that if any change occurs in my health I am to report it to the dental office as soon as possible. I have read and understand each question, and have answered all of them truthfully and to the best of my ability. Upon completion of root canal therapy in this office, I understand that I must return to my general dentist for permanent restoration.

I authorize release of any information relating to this claim. I authorize payment to my dentist of the group insurance benefits otherwise payable to me. I also assume financial responsibility for the fees not payable by my insurance company.

First Name	Last Name	Date of Birth
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Patient Signature (or Authorized Representative)	Date
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#### Our Office Financial Policy

Our doctors and staff appreciate your selection of this office for your endodontic treatment. Our goal is to provide you with the best possible care and to keep the investment in your dental health to a minimum. Our financial coordinator will discuss the fees for the treatment with you. For our patients' convenience, we accept Visa, Mastercard, American Express, Discover, Apple Pay, Care Credit, Check and exact cash.

For our non insured patients, we will provide you with the amount due at the time of your appointment.

For our insured patients, we will submit a claim form as a courtesy to you with the understanding that total payment of the dental service is the responsibility of the patient, and not the insurance company. We will obtain an estimate of your dental coverage from your insurance company prior to your appointment. This is only an estimate and you will be responsible for any balance after your insurance payment. We do ask that your estimated portion be paid at your appointment. Upon receipt of the insurance payment, we will reconcile the account and bill or refund any difference. For those insurance companies we are not currently participating with, we ask for payment in full and reimbursement will be made directly to the subscriber. Our experienced staff will help in every way possible with filing claims and handling insurance problems.

Our fee does not include the cost of a permanent restoration which will be done by your own dentist after your root canal has been completed.

No question is too small for you to ask whether it pertains to your treatment, insurance, or bill.

Please do not hesitate to call if we can be of assistance. Thank You!



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## Consent for Consultation and Endodontic Treatment

### **What are my alternatives to root canal therapy?**

Endodontic treatment has been recommended as a procedure for your tooth in an attempt to prevent the tooth's premature loss by extraction.

Your alternatives to the proposed treatment are to have no treatment done or to have the tooth extracted. If no treatment is done, there is a risk of infection, pain and loss of the tooth. If the tooth is extracted, then some form of an artificial replacement may be considered.

### **What are the possible complications?**

Complications are rare. While no complications may be expected as a result of the proposed endodontic treatment, it is possible that complications may still occur. Most of the complications that can occur are normal consequences of treating teeth that have problems similar to yours.

Some of the possible complications include but are not necessarily limited to the following possibilities: mild to severe pain, infection, swelling, fever, temporary or permanent paraesthesia (numbness) or difficulty opening or closing the jaw. If these complications occur, they may require additional treatment.

Other very rare complications may include a separated instrument, perforation of the tooth, and breakage of the tooth structure upon access to the canal or restoration.

Endodontic treatment is a highly successful procedure for postponing the loss of teeth that would otherwise be extracted. Unfortunately, not all teeth will respond favorably to the treatment. Consequently, it is possible that your tooth may in the future require additional treatment such as another endodontic procedure, surgery, or even extraction.

I understand that in spite of the most conscientious efforts of the doctors, that no guarantee is possible for the success of all endodontic procedures, or for that matter, for any dental procedures.

### **Medication considerations:**

Medication may be given for pain and infection. If given narcotic pain medication, you should not drive an automobile or operate equipment that may be hazardous to yourself or others.

If you are a female who is taking birth control pills, it is possible that you could become pregnant while taking an antibiotic. Consequently, an alternative form of contraception may be appropriate while taking the antibiotic.

### **Follow up care:**

After completion of root canal therapy it is your responsibility to see your restorative dentist for the final restoration of the involved tooth/teeth and to protect your tooth/teeth from decaying or fracturing.

## Consent for consultation and Endodontic treatment

I have read the above and I understand that no treatment is without some measure of risk and the risks of the proposed treatment have been explained to me. ***(Please initial next to the items you are giving consent for and sign the bottom of the form)***

\_\_\_\_\_ I consent for evaluation/consultation and periapical radiograph prior to treatment

\_\_\_\_\_ I consent for a CBCT image be taken (this is a 3D x ray used for diagnostic purposes)

\_\_\_\_\_ I hereby authorize the doctors and their assistants to perform the necessary endodontic testing/procedures which have been described to me. I prefer to undergo the ENDODONTIC (root canal) procedure in order to attempt to postpone the loss of my tooth. I further request and authorize them to do whatever they deem advisable and necessary as a result of unforeseen circumstances. I have been given the opportunity to question the doctor concerning the nature of treatment, the inherent risks of the treatment, and alternatives to this treatment.

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First Name	Last Name	Date of Birth
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Patient Signature (or Authorized Representative)	Date
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Front Desk Witness	Date
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NSRCT Tooth #	_____	Retreatment RCT Tooth #	_____
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