EDWARD K. GAMSON, D.D.S., M.S.
PRACTICE LIMITED TO ENDODONTICS

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PERSONAL HISTORY

Patient's Name_____

Street Address_____

City/State/Zip_____

Birthdate_____ ❑ Male ❑ Female

Home Phone_____Work Phone_____

Cell Phone _____ Email Address _____

Employer (or parent, if child)_____

Occupation_____Emergency Contact _____

Spouse's Name_____ Work Phone_____

Any Dental Insurance? ❑ Yes ❑ No Under Whose Name_____

Dental Insurance Policy and Group Number_____

Insured Party's Social Security Number_____

Insured Party's Date of Birth_____ Method of Payment: Visa MC ❑ Discover Check

General Dentist_____Referred By_____

MEDICAL HISTORY

Name of Your Physician_____

Do you require anitibiotics before dental treatment? ❑ Yes ❑ No If yes, give reason below.

Have you been hospitalized in the last 5 years? ❑ Yes ❑ No

If yes, For What?_____

Please List Medications You Are Taking_____

_____

Do you have, or have you had, any of the following?

Y N	Y N	Y N
❑ ❑ Heart Disease (angina, heart attack, bypass)	❑ ❑ Blood Disorder	❑ ❑ Diabetes
❑ ❑ Heart Murmur	❑ ❑ Malignancies / Cancer	❑ ❑ Excessive Thirst / Urination
❑ ❑ Mitral Valve Prolapse	❑ ❑ Radiation or Chemotherapy Treatment	❑ ❑ Epilepsy or Neurological Problem
❑ ❑ Pacemaker or Artificial Valve	❑ ❑ Thyroid or Parathyroid Condition	❑ ❑ Stroke
❑ ❑ Rheumatic Fever	❑ ❑ Alcohol or Drug Dependency	❑ ❑ Fainting or Dizziness
❑ ❑ High Blood Pressure	❑ ❑ Blood Transfusion: Date of_____	❑ ❑ Sinus Trouble
❑ ❑ Shortness of Breath	❑ ❑ Psychiatric Treatment	❑ ❑ Glaucoma
❑ ❑ Unusual Swelling of Feet/Ankles	❑ ❑ Allergies (list below)	❑ ❑ Ulcer or Colitis
❑ ❑ Lung Disease / Tuberculosis	❑ ❑ Hepatitis A ❑ Hepatitis B	❑ ❑ Women: Are you pregnant?
❑ ❑ Excessive bleeding from cut or Extraction	❑ ❑ Liver Disease	❑ ❑ Women: Taking Birth Control pills?
	❑ ❑ AIDS, HIV Positive	❑ ❑ Organ Transplant
	❑ ❑ Venereal Diseases	❑ ❑ Are you taking Bisphosphonates

Allergies to Medication (ie. Penicillin, "Novocaine" or Codeine)_____

Comments:_____

_____

OVER

DENTAL HISTORY

Do you feel discomfort when your tooth comes in contact with:

Hot Foods or Liquids (Soup, Coffee, etc.?)	❑ Yes	❑ No
Cold Foods or Liquids (Ice Cream. Cold Water, etc?)	❑ Yes	❑ No
Sweet or Sour Foods (Candy, Oranges, Fruit, etc?)	❑ Yes	❑ No
When You Bite Down or Chew?	❑ Yes	❑ No

Do any of the above symptoms linger for more than a minute or so? _____

Comments: _____

_____

_____

Have you ever undergone Endodontic Treatments? ❑ Yes ❑ No

INFORMED CONSENT

• We shall try to advise you as to the expected number of appointments necessary, the time needed for each appointment, what you may expect from the treatment, and the fee. It is understood that endodontic treatment is a procedure to retain a tooth which may otherwise require extraction. Although this treatment has a high degree of clinical success, **it is still a biological procedure and it cannot be guaranteed.** Occasionally a tooth which has had endodontic treatment may require retreatment, surgery. or even extraction.

• Complications of Root Canal Therapy and/or anesthesia may include swelling, discomfort, infection, bleeding, trismus (limited jaw opening), changes in occlusion (biting), jaw muscle and joint cramps and spasms, involvement of the sinuses, and numbness or tingling of the lip, gum, or tongue which rarely is protracted and even more rarely is permanent. During treatment complications may be discovered which make treatment impossible, or which may require dental surgery. These complications may include; blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, gum disease and fractures of the teeth. During treatment fracture of crown or porcelain may occur.

• When your treatment is completed, your tooth will need a final restoration (filling, cap or crown). Our fee does not include this service. Your referring dentist will render this service which is equally important for the preservation of your tooth.

• **Payment: It is expected that payment for all treatment be made in full at the time when treatment is completed. We gladly accept Cash, Check, Visa, Discover or MasterCard.**

• **DENTAL INSURANCE:** As a convenience to you, our office will fill out the necessary forms and submit them to your insurance company. However, we consider each patient responsible for their entire account. As most insurance companies provide coverage from 50% to 80%, we require a minimum of 30% of the fee prior to the completion of your treatment. If your insurance payment is more or less, your account will be adjusted accordingly. All accounts that are more than 60 days overdue will be assessed a finance charge of 15% A.P.R. The signature below verifies patient receipt of Notice of Privacy Practices.

• If you have any questions regarding your treatment or fees, we will be happy to discuss them with you. Should you have any concerns between visits or after completion of your treatment, please do not hesitate to call.

_____ _____

PATIENT'S SIGNATURE DATE

All Signatures Must Be By A Parent Or Guardian If Patient's Age Is 18 Years Or Less.