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 _____ Occupation _____

Emergency Contact _____ Emergency Contact Phone Number _____

INSURANCE INFORMATION

Do you have Dental Insurance? ☐ Yes ☐ No Whose Name is it under? _____ Relationship ☐ Self ☐ Spouse ☐ Parent

Dental Insurance Name _____ Subscriber/Member ID/Social Security # _____

Insured Party's Birthdate _____

Do you have a secondary Dental Insurance? ☐ Yes ☐ No Whose name is it under? _____ Relationship ☐ Self ☐ Spouse ☐ Parent

Secondary Insurance Name _____ Subscriber/Member ID/Social Security # _____

Subscriber's Birthdate _____

MEDICAL HISTORY

Name of Your General Dentist _____ Name of your Physician _____

Do you require pre-medication, antibiotic, before any dental treatment? ☐ Yes ☐ No If yes, what is the reason _____

Please list any medications you are taking _____

Do you have, or have you had, any of the following? **PLEASE ANSWER YES or NO FOR EACH MEDICAL AILMENT**

Y N	Y N	Y N
☐☐ Heart Disease	☐☐ Blood Disorder	☐☐ Ulcer or Colitis
☐☐ Heart Murmur	☐☐ Malignancies/Cancer	☐☐ Sinus Trouble
☐☐ Mitral Valve Prolapse	☐☐ Radiation or Chemotherapy	☐☐ Organ Transplant
☐☐ Pacemaker or Artificial valve	☐☐ Lung Disease/Tuberculosis	☐☐ Allergies (list below)
☐☐ High Blood Pressure	☐☐ Thyroid Condition	☐☐ WOMEN: Are you Pregnant?
☐☐ Stroke	☐☐ Liver Disease	☐☐ WOMEN: Or taking Birth Control pills?
☐☐ Shortness of Breath	☐☐ Diabetes	☐☐ Are you taking Bisphosphonates?
☐☐ Unusual Swelling of Feet/Ankles	☐☐ Epilepsy or Neurological Problem	☐☐ Hepatitis A ☐Hepatitis B/C
☐☐ Fainting or Dizziness	☐☐ Glaucoma	☐☐ AIDS, HIV Positive

Allergies to any medication? (Penicillin, Novocain, Codeine, etc)

_____

_____

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.

_____ _____

PATIENTS SIGNATURE DATE

All Signature Must By A Parent Or Guardian If Patient's Age is 18 Years Or Less