HARRY SINGH, DDS
& ASSOCIATES

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# Patient Registration

## Patient Information

Referred by: _____ Date: _____

Patient Name: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

Home: _____ Work: _____ Cell: _____

E-mail: _____ May we use your email to contact your appointment? (Y) (N)

Have any members of your family been to our office before? (Y) (N)

**Person to notify in case of emergency:**

Name: _____ Phone: _____

## Insurance

Dental Insurance? ☐ Yes ☐ No Name of Insurance: _____

Policy or ID Number: _____ Group Number: _____

Name of Insured: _____ Insured Date of Birth: _____

Secondary Insurance Company: _____

## Statement of Privacy Policy

I certify that I, and/or my dependents have insurance coverage as noted above, and assign directly to the dental office all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance information. The dental office may use my health care information and may disclose such information for the purpose of carrying out my treatment, payment and healthcare operations.

We are committed to protecting medical information about you. The details of our Privacy Policy (The Notice) will tell you about the ways in which we may use and disclose information about you. The Notice also describes your rights and outlines obligations we have regarding the use and disclosure of your information. We are required by law to make sure the medical information we have that identifies you is kept private. We are required by law to give you a copy of our Notice of legal duties and privacy practices, and to follow the terms of the Notice that is currently in effect. The Notice of our Privacy Policy can be obtained when you visit our office.

Parent or Legal Guardian Name: _____

Relation to Patient: _____

By signing this form, I acknowledge that I have read the above statements and agree to their content.

Patient or Legal Guardian Signature: _____ Date: _____

**Progressive Endodontics LLC ~ 585-256-1500**

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# Medical History

## Allergies (Please check all that apply)

- ☐ Latex
- ☐ Sulfa
- ☐ Penicillin
- ☐ Aspirin
- ☐ Codeine
- ☐ Erythromycin
- ☐ Other:_____
  _____
  _____
- ☐ **None**

## Medical History (Please check all that apply)

- ☐ Diabetes
- ☐ HIV/AIDS
- ☐ Cancer
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Anemia
- ☐ Kidney Disease
- ☐ Ulcers
- ☐ Hormone/Birth Control
- ☐ Heart Disease
- ☐ Pacemaker
- ☐ Blood Thinners
- ☐ Pregnant/Nursing
- ☐ Blood Disease
- ☐ Stroke
- ☐ Osteoporosis
- ☐ Tumors
- ☐ Hip or Joint replacement
  -If Yes when_____
- ☐ Epilepsy/Seizures
- ☐ **None**

## Medications

- Are you currently taking medication for **osteoporosis**? ☐Yes ☐No
- Do you **routinely take antibiotics** before dental appointments? ☐ Yes ☐ No
- Do you have a Primary Care Physician? ☐Yes Dr. _____ ☐ No

List medications that you are currently taking:

_____

_____

Pharmacy Name/Location: _____

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# Consent for Root Canal Therapy

I hereby consent to examination and treatment, as deemed necessary, by the attending endodontist.

Please review this consent. You are required to sign it prior to the start your appointment; it does not commit you to treatment.

- **The success of root canal therapy is influenced by many factors**. Your general health, adequate gum attachment and bone support, shape and condition of the roots and nerve canals, quality of previous dental care, and pre-existing root fractures all affect individual healing.
- **Teeth treated with root canal therapy can still decay.** Because the nerve is gone there will be no pain. Good oral hygiene and periodic checkups are necessary for maintaining good dental health.
- **Treated teeth may remain sensitive following treatment.** If sensitivity persists and does not seem to improve, phone the office for an appointment. Usually administration of an appropriate medication will quickly resolve the problem. It is normal for a treated tooth to be sensitive for up to one week following the final appointment, and to feel different than the surrounding teeth for an additional two weeks.
- **In some cases, regular root canal therapy alone may not be sufficient.** If the canals are severely curved or calcified, if there is substantial infection in the bone around the roots, or if an instrument breaks and

remains in the canal, the tooth may remain sensitive and endodontic surgery may be necessary to resolve the problem.

- **Following root canal therapy the tooth is more susceptible to fracture.** To prevent damage that may cause the loss of the tooth, you must see your general dentist for the final restoration. In some cases a filling is adequate, in other cases your dentist will recommend a cap or crown.
- **Root fracture is the one of the most common reasons root canal therapy fails.** Unfortunately, some cracks that extend from the crown down into the roots are invisible and undetectable. They can occur from traumatic injury, biting on hard objects, habitual clenching or grinding, and even normal wear and tear. If present, a crack can affect the long term prognosis, depending on the size and extent.
- **There are alternatives to root canal therapy.** They include extraction, extraction following by a bridge, partial denture, implant, or no treatment at all.

**Informed consent:**

I have read the consent form and its contents and specific information noted. I certify that I have had an opportunity to ready fully, and understand the terms and words within this consent. I hereby give my consent to be examined and treated as necessary.

_____ Date: _____

Patient Signature (Guardian if patient is a minor)