

# Boise Endodontics

THE FOLLOWING CONFIDENTIAL INFORMATION IS FOR OUR RECORDS ONLY  
(Please Print)

### Patient Information

Patient Name \_\_\_\_\_ Age \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Home Address \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Patient Employed By \_\_\_\_\_  
 Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Spouse Name (Parent if Minor) \_\_\_\_\_ Business Phone \_\_\_\_\_  
 Spouse Employer (Parent if Minor) \_\_\_\_\_ City/St./Zip \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
 Referring Dentist \_\_\_\_\_ General Dentist \_\_\_\_\_

### Insurance Information

Primary **Dental** Insurance \_\_\_\_\_ Ins. Phone # \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_ Subscriber # \_\_\_\_\_  
 Subscriber Date of Birth \_\_\_\_\_ Subscriber's Employer \_\_\_\_\_  
 Secondary **Dental** Insurance \_\_\_\_\_ Ins. Phone # \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_ Subscriber # \_\_\_\_\_  
 Subscriber Date of Birth \_\_\_\_\_ Subscriber's Employer \_\_\_\_\_

Provided with your insurance information, we will gladly file your insurance claims. **However, please keep in mind that benefit reimbursement is a contract between you and your insurance company.** I authorize the release of my information required by my insurance company. I also authorize payment of benefits directly to the dentist.

Signature \_\_\_\_\_ Date \_\_\_\_\_

### PLEASE FILL OUT THE FOLLOWING IF YOU HAVE EXPERIENCED ANY PAIN FROM YOUR TEETH:

Is the pain localized to a definite area of your mouth? .....  Yes  No  
 Is it a specific tooth? .....  Yes  No  
 Does any particular stimulus produce the pain? - Hot, cold, sweetness, pressure, chewing, lying down, etc.?  
 Please List: \_\_\_\_\_  
 Is the pain described as being sharp, throbbing or a dull ache? \_\_\_\_\_  
 Does the pain last for seconds, minutes, or is it continuous? \_\_\_\_\_  
 Does the pain spread to other areas of your mouth or head? .....  Yes  No  
 Does the tooth in question feel misaligned or out of position? .....  Yes  No  
 When did the toothache start? \_\_\_\_\_  
 Is there swelling? .....  Yes  No When did the swelling start? \_\_\_\_\_  
 Did you ever suffer a blow to this area of your mouth? . . . .  Yes  No When? \_\_\_\_\_

**Medical History**

Medical Physician's Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Are you in good health?.....  Yes  No

Has there been any change in your health in the last year?.....  Yes  No

Are you presently under the care of a physician?.....  Yes  No

When was your last medical examination? \_\_\_\_\_

Have you ever been seriously ill?.....  Yes  No

Have you ever been hospitalized?.....  Yes  No

Check any of the following that you have or have had:

- |   |   |   |                                       |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Heart Condition    | <input type="checkbox"/> Thyroid/Hormonal     | <input type="checkbox"/> Migraine/Headaches   | <input type="checkbox"/> MVP          |
| <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Epilepsy/Fainting    | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> H/L Blood Pressure | <input type="checkbox"/> Sinusitis            | <input type="checkbox"/> Glaucoma/Visual      | <input type="checkbox"/> HIV/AIDS     |
| <input type="checkbox"/> Respiratory/Asthma | <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Mental/Neural        | <input type="checkbox"/> Phen/Phen    |
| <input type="checkbox"/> Rheumatic Fever    | <input type="checkbox"/> Radiation/Chem       | <input type="checkbox"/> Tumor/Neoplasms      | <input type="checkbox"/> Herpes       |
| <input type="checkbox"/> Jaundice/Liver     | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Alcoholism/Addiction | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Immunocompromised  | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Infectious Diseases  | _____                                 |
| <input type="checkbox"/> Anemia/Bleeding    | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Venereal Disease     | _____                                 |
| <input type="checkbox"/> Diabetes/Kidney    | <input type="checkbox"/> Ulcers/Digestive     | <input type="checkbox"/> Joint Replacement    | _____                                 |

Please list any **ALLERGIES** to medications or foods:

\_\_\_\_\_

Are you taking any medicines, supplements or herbals?.....  Yes  No

If yes, please list: \_\_\_\_\_

Do you stop bleeding normally after a cut or injury?.....  Yes  No

Do you heal normally?.....  Yes  No

If female, are you pregnant?.....  Yes  No

**The Purpose** of endodontic treatment or root canal treatment is an attempt to save a tooth rather than removing it. Although treatment has a high degree of success, it can't be guaranteed. Occasionally, when a tooth has had a root canal treatment, it may require re-treatment, surgery, or even extraction.

Treatment is usually a non-surgical procedure, but in some cases, a surgical approach is necessary. Before any treatment is begun the reason(s) will be explained, including alternative modes of therapy. Occasionally, pre-medication may be indicated. This will be discussed in advance.

**PLEASE NOTE: The fee will not include a permanent filling or crown on the tooth. You must return to your general dentist to have your treatment completed.**

Consent is hereby given to Boise Endodontics and to the treating Endodontist to administer treatment that is deemed necessary. I agree to pay all fees incurred for exams and/or treatment in this office. 1.5% per month will be assessed on all accounts that are over 60 days (\$1.00 minimum)

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Notice of Privacy Practices**

I acknowledge that I have been given or offered a copy of this office's Privacy Practices information.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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