ENDODONTIC SPECIALTY GROUP
of greater vancouver

# CONFIDENTIAL PATIENT INFORMATION

Last Name: _____ First Name: _____ Date of Birth: _____/_____/_____
Mr. Mrs. Ms. Dr. M D Y

Address: _____ City: _____ Postal Code: _____

Home phone: _____ Cell phone: _____ Bus phone: _____ Ext: _____

Email: _____ Occupation: _____ Employer: _____

Do you have dental insurance? YES NO

First Insurance Co.: _____ Policy holder: _____ Policy holder's birthdate: _____/_____/_____

Group/Policy #:_____ Certificate / I.D.# _____ M D Y

(if applicable)
Second Insurance Co.: _____ Policy holder: _____ Policy holder's birthdate: _____/_____/_____

Group/Policy #:_____ Certificate / I.D.# _____ M D Y

Legal Guardian (if patient is a minor): _____ Phone: _____

Referring Dentist: _____ Phone: _____

Family Physician: _____ Phone: _____

## MEDICAL HISTORY

**Please circle:**

1. Are you presently under the care of a physician? (regularly for a particular medical condition) YES NO

   If YES, explain: _____

2. Have you ever been hospitalized or had surgery? YES NO

   If YES, explain: _____

3. Are you presently taking any medications? YES NO

   List: _____

4. Do you have any allergies? YES NO

   ☐ Penicillin ☐ Latex ☐ Local Anesthetic ☐ Aspirin ☐ Sulfa ☐ Other:_____

5. Have you ever taken bisphosphonate medication for osteoporosis (ie. Fosamax)? YES NO

6. Do you require pre-medication for dental procedures? (antibiotics, sedative, etc.) YES NO If YES, list:_____

7. Have you ever had an unfavorable reaction following dental treatment? YES NO

   If YES, explain: _____

8. Have you ever had excessive bleeding requiring special treatment? (ie. extractions or surgery) YES NO

   If YES, explain: _____

9. WOMEN ONLY: Are you pregnant? YES NO If YES, what is estimated delivery date:_____
   Do you take birth control pills? YES NO
   Are you nursing? YES NO

Turn page over ➔

10. Do you have or have you ever had any of the following? Please check:

☐ High/ low blood pressure
☐ Heart disease/ heart attack
☐ Stroke
☐ Heart surgery
☐ Angina pectoris
☐ Heart murmur
☐ Heart rhythm disorder
☐ Cardiac pacemaker
☐ Artificial heart valve
☐ Rheumatic fever
☐ Mitral valve prolapse
☐ Congenital heart defects
☐ Anemia
☐ Blood disorder
☐ Blood transfusion
☐ Asthma
☐ Difficulty breathing
☐ Lung disease
☐ Emphysema
☐ Sinus trouble/ sinusitis
☐ Fainting spells or seizures
☐ Epilepsy
☐ Diabetes
☐ Thyroid disease
☐ Liver disease (cirrhosis)
☐ Hepatitis A / B / C
☐ Stomach problems
☐ Ulcers
☐ Kidney disease
☐ Dialysis
☐ Jaw joint (TMJ) problems
☐ Headaches/ migraines
☐ Head/ neck injuries
☐ Arthritis/ rheumatism
☐ Artificial joints (hip, knee, etc.)
☐ Drug/ alcohol dependence
☐ Anxiety/ nervous disorder
☐ Psychiatric disorder
☐ Eye disease or glaucoma
☐ Cancer
☐ Radiation/ chemotherapy
☐ Venereal disease
☐ Contagious diseases
☐ Tuberculosis
☐ Cortisone/ steroid treatment
☐ Problems with immune system
☐ HIV positive or AIDS

## OFFICE POLICY

- An exam, immediate pre-treatment radiograph, plus diagnostic and treatment radiographs in addition to any radiographs from your dentist **are necessary for care**, as well as the application of **anesthesia** and the use of **rubber dam isolation.** A small field cone beam CT scan may be required either before or mid-treatment to facilitate treatment planning and treatment progress. This fee is not covered by the exam or treatment fee.
- Radiographs and intraoral photos may be used for teaching purposes.
- The **examination/consultation fee** is a **separate charge** from the root canal treatment fee estimate. The examination is necessary for proper diagnosis of your problem and consultation on treatment options.
- The root canal treatment fee estimate is an estimate with a range of what we think the approximate cost may be depending on the complexity of your treatment. We try our best for the final fee to stay within the estimate.
- During the course of treatment, the **complexity and prognosis for endodontic therapy may change**, which may then **affect** the **number, type and scheduling** of **appointments** needed, as well as the **estimate**.
- **Root canal treatment does not include the permanent filling** that is required after treatment is completed (ie. filling, crown, post, bridge, etc.). This must be done by your general dentist. The fee for the filling is a separate cost.
- Appointments cancelled by you within 48 hours (2 business days) of scheduled treatment are subject to a fee of $200 per hour that you are scheduled for.
- **Our fees will be charged directly to you** and **not to** your **insurance** company. We do not deal with the insurance company, but as a courtesy, we can assist you in filling out your insurance claim form, which you will submit directly for your reimbursement.
- **Insurance companies do not cover 100% of specialist fees**. They will reimburse you according to their fee schedule and what the contract in your policy covers.
- **All payments are due at the time of treatment.** We accept Visa, MasterCard, and Debit. All fees collected towards your treatment are **non-refundable**.
- If treatment is aborted or cannot be completed due to complications with the tooth, the Root Canal fee will be reduced by half, all other fees (ie. access through the crown, post removal, etc.) will still apply. Your insurance company will not cover this fee.
- Fees collected for root canal treatment, including emergency treatment, is **non-refundable** should you wish not to continue treatment.

**I certify that I have read and understood the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold the dentist or any member of his/her staff responsible for actions they take or do not take because of errors or omissions that I have made in completing and updating this form.**

**SIGNATURE:** _____ **DATE:** _____