PATIENT INFORMATION (Please Print)

Title: _____ First Name: _____ MI: ____ Last Name: _____

Birthdate: _____ Soc. Sec.: _____ Gender: ◯ Male ◯ Female

Address: _____ Apt./Suite: _____

City: _____ State: _____ Zip Code: _____

Phones: Home: _____ Work: _____ Ext: _____

Mobile: ( ) - _____ Fax: _____ Email: _____

Employer: _____ Phone: ( ) - _____ Occupation: _____

Referred By: _____ _____ General Dentist: _____ _____

Have you been seen in this practice before today? ◯ Yes ◯ No

PERSON RESPONSIBLE FOR ACCOUNT (if other than patient)

Title: _____ First Name: _____ MI: ____ Last Name: _____

Relationship to Patient: ☐ patient ☐ spouse ☐ child ☐ other - please specify _____ Soc. Sec.: _____

Address: _____ Apt./Suite: _____

City: _____ State: _____ Zip Code: _____

Phones: Home: _____ Work: _____ Ext: _____

Mobile: ( ) - _____ Fax: _____ Email: _____

Employer: _____ Phone: ( ) - _____ Occupation: _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Ins. Co. _____

Group #: _____ Phone: _____

Employer: _____

Employee (if other than patient)

Name: _____ _____

Birthdate: _____ Soc. Sec.: _____

Subscriber #: _____ Sex: ◯ Male ◯ Female

Secondary Insurance

Ins. Co. _____

Group #: _____ Phone: _____

Employer: _____

Employee (if other than patient)

Name: _____ _____

Birthdate: _____ Soc. Sec.: _____

Subscriber #: _____ Sex: ◯ Male ◯ Female

_____ _____ _____ _____

Signature (parent or guardian if patient is a minor) Date Signature of authorized representative of Merrimack Valley Endodontics Date

MERRIMACK VALLEY ENDODONTICS

The Mill, Suite #202
73 Princeton Street
N. Chelmsford, MA 01863
tel (978)251-1515
fax (978)251-1616
www.mvendo.com

Medical History

Do you have or have you ever had:

yes ❑ no ❑	Anemia	yes ❑ no ❑	Heart Disease (attack)	yes ❑ no ❑	Rheumatic Fever
yes ❑ no ❑	Arthritis	yes ❑ no ❑	Hepatitis (liver disorders)	yes ❑ no ❑	Stroke
yes ❑ no ❑	Asthma	yes ❑ no ❑	High Blood Pressure	yes ❑ no ❑	Thyroid Disease
yes ❑ no ❑	Bleeding problems	yes ❑ no ❑	HIV Positive	yes ❑ no ❑	Ulcer or Stomach Ailments
yes ❑ no ❑	Diabetes	yes ❑ no ❑	Kidney Disease	yes ❑ no ❑	Allergy to Penicillin
yes ❑ no ❑	Emphysema	yes ❑ no ❑	Osteoporosis Medications	yes ❑ no ❑	Allergy to Latex
yes ❑ no ❑	Epilepsy / Seizures	yes ❑ no ❑	Any known drug allergies _____		

Do you routinely take antibiotics prior to dental appointments (premedication)? yes ❑ no ❑

Women: yes ❑ no ❑ Are you pregnant? Due Date _____

yes ❑ no ❑ Do you take birth control pills?

Medications currently taking _____

Do you have any other medical conditions or diseases? _____

Consent for Treatment

Please read the following information and sign below to indicate that you understand to your satisfaction the contents and specific information noted, and that you consent for Drs. Carter/Gilad/Ly and his/her assistants to examine and provide endodontic therapy for your tooth/teeth or other procedures deemed necessary to complete the planned treatment. Please ask your Doctor if you have any questions.

- ***The success of root canal therapy is influenced by many factors.*** Your general health, adequate gum attachment and bone support, pre-existing condition of the tooth, shape and condition of the roots and nerve canals and preexisting root fractures may all affect individual healing and outcome.
- ***Teeth treated with root canal therapy can still decay.*** Good oral hygiene and periodic check-ups are necessary for maintaining dental health.
- ***The treated teeth may remain sensitive following the appointment.*** It is normal for a treated tooth to remain sensitive, especially to biting pressure immediately following root canal therapy. These symptoms generally subside within one week. Additionally the tooth may feel different from the adjacent teeth for several weeks.
- ***In some teeth, regular root canal therapy alone may not be sufficient.*** If the canals are severely curved or calcified, if the infection is extensive, or if an instrument separates and remains in the canal, then an additional procedure may be necessary in order to achieve proper healing.
- ***It is recommended that you see your dentist for follow-up care,*** which may include placing a permanent filling and/or crown on the tooth, to prevent it from breaking in the future. Root canal treated teeth tend to be structurally less strong than other teeth, and may be more prone to breaking or fracturing if not protected by a crown (cap). On rare occasions, the tooth can fracture in spite of being crowned.
- ***Root fracture is one of the main reasons for root canal failure.*** Fracture lines that extend down onto the roots can be invisible and undetectable. They can occur on uncrowned teeth from traumatic injury, biting on hard objects, habitual clenching and grinding, and even just normal wear and tear. Severely fractured teeth, whether before or after endodontic treatment are generally extracted.
- ***There are alternatives to root canal therapy.*** They include extraction, extraction followed by a bridge, partial denture or implant or no treatment at all.

_____ _____

Patient Signature *(Guardian if patient is a minor)* Date

MERRIMACK VALLEY ENDODONTICS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Merrimack Valley Endodontics is required by applicable federal and state law to maintain the privacy of your health information. We are also required to provide you a Notice of Privacy Practices that explains our privacy practices, legal duties and your rights concerning health information.

I have had opportunity to read and consider the contents of your Notice of Privacy Practices. I understand that in signing this acknowledgement form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempt to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

MERRIMACK VALLEY ENDODONTICS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available to you upon request.

You may request a copy of our Notice at any time. Please contact us for any further information about our privacy practices.

USES AND DISCLOSOURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a dentist or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: Your healthcare information is sometimes used to assess and improve quality of care. Non-patient specific information is used whenever possible.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time.

To Your Family, Friends and Other Persons Involved In Your Care: Only if you agree that we may do so will we disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up radiographs or other forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications.

Required by Law: We may use or disclose your health information when we are required to by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution of law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters.)