ENDODONTIC SPECIALTY GROUP

JARED E. LICHSTRAHL, DMD • EDWARD R. KIRSH, DDS & ASSOCIATES

Dear Patient,

Welcome! Thank you for contacting our office. *Please complete the three-page registration and health history form as well as any other included forms and bring it with you to your appointment.** The following guidelines will help you in preparation for your visit:

1) Please bring your referral information and x-rays, if any, from your restorative dentist. You can expect that new diagnostic x-rays will be taken at our office regardless.

2) Eat breakfast or lunch before your appointment to ensure a normal blood glucose level. Please DO NOT drink caffeinated drinks, such as regular coffee due to effects on blood sugar and anesthetics.

3) **Arrive at least 20 minutes early** to complete a few additional forms. Bring a complete list of all medications and dosages with you.

4) Take all your routine medications, including aspirin therapy, if applicable. However, **DO NOT take medication for discomfort** (i.e., ibuprofen, Advil, Motrin, Aleve, Percocet, Vicodin, etc.) prior to the first visit because it may mask symptoms and hinder diagnosis.

5) If you require prophylactic antibiotics before dental visits for a prosthetic heart valve or orthopedic prosthesis (artificial hip, knee, elbow, etc.), please call our office for instructions. If you've already discussed this with us or your physician, or you knowingly take these medications before a dental visit, you **do not** need to call again.

6) Please let us know if you take blood thinners (Coumadin (warfarin sodium), Elequis etc.) so we can arrange in advance to receive your current INR readings if needed. This is usually for Surgery and **NOT** Routine root canal treatment.

7) **After your treatment is completed you MUST return to your General Dentist to have the tooth restored or fixed with a permanent filling or a crown.** Not doing so may result in infection, re-infection and/or a fracture that will result in need for the removal of your tooth.

8) Our office hours are from 8:30 am until 5:00 pm, Monday-Friday. Occasionally, last minute emergency patients can delay our schedule, so please allow a little extra time for your appointment. We value your time and will try to keep you updated when delays occur.

9) All patients under the age of 18 must be accompanied on each visit by their parent or legal guardian.

10) If you have not already done so, please explore our website at https://endosg.com to learn more about our doctors and office.

11) Insurance: Endodontic fees are based on the complexity of the procedures necessary. We will make every effort to help you receive reimbursement by your insurance carrier, so please bring your dental and medical insurance information with you. Drs. Kirsh, Lichstrahl and their Associates participate with a variety of insurance carriers. We welcome any questions you may have about payments and insurance benefits. We look forward to being of service to you. If you have any questions, please don't hesitate to call us.

*Completion of these forms does not constitute the establishment of a doctor-patient relationship.

ENDODONTIC SPECIALTY GROUP

PATIENT REGISTRATION AND HEALTH HISTORY FORM

PATIENT INFORMATION

❑ Mr. ❑ Ms. ❑ Mrs. ❑ Dr.

First Name _____MI_____Last Name_____

Sex: ❑ M ❑ F Date of Birth _____SSN _____

Street _____City _____

State_____ Zip _____ Email _____

Cell_____ Work_____Alt Phone _____

Employed by / Occupation _____

General dentist _____ Referred by _____
(First and Last name) (Please write "same" if referred by general dentist)

Physician _____ Phone _____

Pharmacy_____ Address_____ Phone_____

EMERGENCY CONTACT

In case of emergency contact _____ ❑ Spouse ❑ Father ❑ Mother ❑ Other

Emergency Cell _____ Emergency Alt Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____
(First Name) (M.I.) (Last Name)

Subscriber's Name_____Date of Birth_____ Relationship to Patient_____

Subscriber ID#_____ Group Number_____

Insurance Name _____ Insurance Phone _____

REASON FOR VISIT

What is the reason for your visit today? _____

How long have you had this problem? _____

What are your symptoms? _____

Check (✓) if you have had problems with any of the following:

❑ Dry mouth	❑ TMJ-Jaw problems	❑ Periodontal treatment	❑ Sensitivity to cold
❑ Bleeding gums	❑ Grinding teeth	❑ Sores or growths in your mouth	❑ Sensitivity to hot
❑ Head/Neck Injury	❑ Loose teeth or broken fillings	❑ Sensitivity when biting	❑ Sensitivity to sweets

MEDICAL HISTORY

Please answer the following questions to the best of your knowledge. Although endodontists primarily treat the mouth area, medical problems or medications could have a significant impact on your dental treatment. Your answers are confidential.

❑ Y ❑ N Are you under the care of a physician? Date of last physical examination: _____

❑ Y ❑ N Have you had any illness, operation, or been hospitalized in the past five years (for what)? _____

_____

- ❑ Heart valve replacement or vascular graft
- ❑ Damaged heart valves/prosthetic valve
- ❑ Heart attack(s)/myocardial infarction (MI)
- ❑ Irregular heart beat/tachycardia
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Chest pain/angina
- ❑ Mitral valve prolapse/heart murmur
- ❑ Rheumatic Fever/Rheumatic Heart Disease
- ❑ Cardiac pacemaker
- ❑ Heart surgery/bypass surgery
- ❑ Stroke/Transient Ischemic Attack (TIA)
- ❑ Blood transfusion
- ❑ Blood disorder/anemia
- ❑ Bruise easily
- ❑ Abnormal bleeding
- ❑ Convulsions/epilepsy
- ❑ Parkinson's disease
- ❑ Bronchitis/chronic cough
- ❑ Asthma
- ❑ COPD
- ❑ Respiratory problems
- ❑ Tuberculosis
- ❑ Emphysema
- ❑ Eye disease/glaucoma
- ❑ Hepatitis/jaundice/liver disease
- ❑ HIV/AIDS/STD
- ❑ Contagious diseases
- ❑ Infectious mononucleosis
- ❑ Fainting spells
- ❑ Thyroid trouble
- ❑ Diabetes
- ❑ Low blood sugar
- ❑ Swollen ankles/joint disease
- ❑ Arthritis/joint disease
- ❑ Prosthetic joint implant _____
- ❑ Gallbladder trouble
- ❑ Stomach ulcers/GERD
- ❑ Irritable bowel syndrome
- ❑ Kidney trouble
- ❑ Are you on dialysis
- ❑ Delay in healing
- ❑ Tumor/ growth
- ❑ Breast surgery of any type
- ❑ Radiation/chemotherapy/cancer
- ❑ Are you on a diet
- ❑ Immune system problems
- ❑ Malignant hyperthermia
- ❑ Chronic fatigue
- ❑ Smoking/chewing tobacco
- ❑ A history of drug abuse
- ❑ A history of alcohol abuse
- ❑ Mental health problems
- ❑ Other: _____

MEDICATIONS

Check (✓) if you are you taking any of the following medications *(and their generics)*:

- ❑ Allopurinol *(Zyloprim)*
- ❑ Alprazolam *(Xanax)*
- ❑ Amlodipine *(Norvasc)*
- ❑ Amoxicillin *(Amoxil)* - Amoxicillin/Potassium Clavulanate *(Augmentin)*
- ❑ Amphetamine/Dextroamphetamine *(Adderall)*
- ❑ Atenolol *(Tenormin)*
- ❑ Atorvastatin Calcium *(Lipitor)*
- ❑ Azithromycin *(Zithromax)*
- ❑ Bupropion *(Wellbutrin)*
- ❑ Carvedilol *(Coreg)*
- ❑ Cialis
- ❑ Citalopram *(Celexa)*
- ❑ Clindamycin
- ❑ Clopidogrel *(Plavix)*
- ❑ Crestor
- ❑ Cyclobenzaprine *(Flexeril)*
- ❑ Duloxetine *(Cymbalta)*
- ❑ Escitalopram *(Lexapro)*
- ❑ Fenofibrate *(Tricor)*
- ❑ Fluoxetine *(Prozac)*
- ❑ Fluticasone *(Flonase)*
- ❑ Furosemide *(Lasix)*
- ❑ Gabapentin *(Neurontin)*
- ❑ Hydrochlorothiazide *(Microzide)*
- ❑ Hydrocodone/Acetaminophen *(Lortab)*
- ❑ Levothyroxine *(Synthroid)*
- ❑ Lisinopril *(Prinivil)*
- ❑ Lisinopril/HCTZ *(Zestoretic)*
- ❑ Losartan Potassium *(Cozaar)*
- ❑ Losartan *(Cozaar)*
- ❑ Meloxicam *(Mobic)*
- ❑ Metformin *(Glucophage)*
- ❑ Methylprednisolone *(Medrol)*
- ❑ Metoprolol ER *(Toprol XL)*
- ❑ Metoprolol *(Lopressor)*
- ❑ Montelukast *(Singulair)*
- ❑ Omeprazole *(Prilosec)*
- ❑ Pantoprazole *(rotonix)*
- ❑ Potassium Chloride *(Klor-Con)*
- ❑ Pravastatin *(Pravachol)*
- ❑ Prednisone *(Deltasone)*
- ❑ Sertraline *(Zoloft)*
- ❑ Simvastatin *(Zocor)*
- ❑ Tamsulosin *(Flomax)*
- ❑ Tramadol *(Ultram)*
- ❑ Trazodone *(Oleptro)*
- ❑ Venlafaxine *(Effexor)*
- ❑ Ventolin
- ❑ Warfarin *(Coumadin)*
- ❑ Zolpidem *(Ambien)*

❑ **Bone density / Osteoporosis Medications / Injections**: *Actonel, Aredia, Atelvia, Boniva, Didronel, Fosamax, Prolia, Zometa*

Please list all medications you are **currently** taking including antibiotics and pain medications:

1. _____
2. _____
3. _____
4. _____

ALLERGIES

❑ **NONE**
❑ Penicillin, Amoxicillin, Augmentin
❑ Aspirin, Advil, Motrin, Ibuprofen
❑ Sulfa/sulfites
❑ Valium or other tranquilizers
❑ Local anesthetic (novocaine, adrenalin,epi)
❑ Codeine or other narcotics
❑ Latex
❑ Other _____

WOMEN

❑ Y ❑ N Are you pregnant? If yes, estimated delivery date: _____
❑ Y ❑ N Is there a possibility of pregnancy?
❑ Y ❑ N Are you nursing?
❑ Y ❑ N Are you taking birth control pills? (Antibiotics, such as penicillin, may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control if antibiotics are prescribed.)

ALL PATIENTS

❑ Y ❑ N Do you have a medical condition that requires you to take antibiotics prior to dental treatments?
❑ Y ❑ N Is there any health condition about which the doctor should know?
❑ Y ❑ N Do you wish to speak to the doctor privately about anything?

Authorization

I authorize my endodontist and his/her staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. If medically necessary, I authorize the release of any information acquired in the course of my examination and treatment.

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my endodontist, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form. I understand that I am responsible for notifying my endodontist of any medical changes upon each visit.

X _____

Patient Signature (Parent or Guardian if minor) **Print Full Name** **Date**

Doctor: _____ Witness: _____

Acknowledgement of Receipt of Notice of HIPAA Privacy Practice

Endo Group, PLLC DBA Endodontic Specialty Group **Notice of Privacy Practices** provides information about how our practice might use and disclose protected health information about you and is compliant with requirements of the Health Insurance Portability Act of 1996 (HIPAA). Our **Notice of Privacy Practices** states that we reserve the right to change the terms described. Should this happen, a notice will be prominently posted in our offices. You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions; but if we do, we are bound by our agreement with you.

Consent for Use and Disclosure of Information

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Insurance carrier benefits be made on my behalf to Endo Group, PLLC DBA Endodontic Specialty Group for any services furnished to me by that provider. I authorize any holder of medical information about me to release to all Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier Agreements.

X _____

Patient Signature (Parent or Guardian if minor) **Print Full Name** **Date**

FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have questions or would like additional information, please contact the HIPAA Policy Officer for the practice. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health and Human Services. There will be no retaliation for filling a complaint.

Record of Discussion and Informed Consent for Evaluation and Non-Surgical Endodontic Treatment

Please read both pages (Front/Back), initial each paragraph and sign the following information. Your complete understanding of the benefits, risks and outcome of your treatment is important to us. We will be pleased to answer any questions you may have.

_____ 1. Examination, X-Rays, Cone Beam CT's and other diagnostic procedures are required for diagnosis and treatment. **If there are any questionable findings on these diagnostic images that are beyond the scope of endodontics, these images may need to be referred to an oral radiologist for further study.**

_____ 2. Root canal therapy is an attempt to save a tooth which otherwise may require removal. While Endodontic Treatment has a high degree of success. As with any medical or dental treatment, this treatment has no guarantee of success for any length of time. Previously treated teeth have a lower rate of success. There are certain risks inherent in any treatment plan or procedure. I understand the risks include but are not limited to: complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. The complications include, but are not limited to: swelling, sensitivity, bleeding, pain, infection, cold sores, numbness and tingling sensation (paresthesia) in the lip, tongue, chin, gums, cheeks and teeth which are transient in most cases but on infrequent occasions may be permanent; reactions to injections, changes in occlusion (biting); jaw muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of the teeth, crowns or bridges; referred pain to ear, neck and head; nausea, vomiting, allergic reactions, delayed healing, sinus perforations, discoloration of the face and treatment failure. Fractures of the tooth (teeth) or crown(s) may occur during or after treatment.

_____ 3. Specific to non-surgical root canal therapy, risks include, but are not limited to, the risks stated in paragraph one (1) above. However, additional risks are possibility of instruments broken within the root canals; perforations (extra openings) of the crown or root of the tooth; damage to crowns, bridges, existing fillings, or porcelain veneers; loss of tooth structure in gaining access to canals, and cracked teeth. During treatment, complications may be discovered which make treatment impossible and which may require dental surgery. These complications may include, but are not limited to, blocked canals due to filling or prior treatment, natural calcification, broken instruments, curved roots, periodontal (gum) disease and fractures of the teeth.

_____ 4. I do understand that during and following treatment, I may have periods of pain or discomfort. I further understand that many factors contribute to the success or failure of root canal therapy that cannot be determined in advance. Therefore, in some cases treatment may have to be discontinued before it is completed or may fail following treatment. Some of these factors include, but are not limited to, my resistance to infection, the shape and location of the canal anatomy, my failure to keep scheduled appointment(s), the failure of my having the tooth restored following the treatment, periodontal (gum) involvement, or an undetected or an "after-the-fact" caused fracture in the tooth. I further understand that during and following treatment, I am to contact the Endodontic Specialty Group if I have any additional questions, and/or if I experience any unexpected reactions. It will be my responsibility to contact my restorative dentist to schedule an appointment for the restoration of the tooth/teeth after treatment.

_____ 5. I further understand that prescribed medications and drugs may cause drowsiness and lack of awareness and coordination, which may be exaggerated by the use of alcohol, tranquilizers, sedatives or other drugs. It is not advisable to operate any vehicle or hazardous device until recovered from their effects. The use of antibiotic drugs may make birth control pills ineffective.

_____ 6. I further understand that I am entering into a contractual relationship with Dr. Lichstrahl, Dr. Kirsh or their Associates for professional care. I further understand that meritless and frivolous claims for dental malpractice have an adverse effect upon the cost and availability of dental care and may result in irreparable harm to a dental provider. As additional consideration for professional care provided to me by Dr. Lichstrahl, Dr. Kirsh or their Associates, I, agree not to advance, directly or indirectly, any false, meritless, and frivolous claim(s) of medical/dental malpractice against Dr. Lichstrahl, Dr. Kirsh or Associates.

_____ 7. Furthermore, should a dental malpractice case or cause of action be initiated or pursued, I agree to use expert witness(es) who practice primarily in the same specialty as the doctors of the Endodontic Specialty Group. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and/or code of conduct defined for expert witnesses by the American and Florida Dental Association. In further consideration for this, Dr. Lichstrahl, Dr. Kirsh and their Associates agree to the same stipulations.

_____ 8. I have read and understood the above information and will be given the opportunity to ask questions and receive answers in words I understand concerning the nature of the treatment, the inherent risks of the treatment, the alternative(s) to this treatment, if any, and its/their risks. I agree I will ask the doctor not to proceed unless and until all my questions have been answered to my reasonable satisfaction. I understand that I will always have the option of no treatment or extraction as opposed to acceptance and/or continuance of the recommended treatment. I understand that root canal treatment is an attempt to save a tooth that may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed, and no guarantees have been made. Occasionally, a tooth that has had root canal therapy may require retreatment, surgery or even extraction.

_____ 9. I understand that I must visit my general dentist for a final restoration after endodontic treatment is completed.

_____ 10. I have followed all pre-operative instructions provided by the Endodontic Specialty Group or my medical and other dental care providers. If I have completed a MEDICAL HISTORY FORM on this visit or on a past visit, there have been no changes except those noted on my latest MEDICAL HISTORY CHANGE FORM.

SIGNATURE: X _____ DATE:_____

ENDODONTIC SPECIALTY GROUP

Practice Limited to Endodontics

Record of Discussion and Informed Consent for CBCT

1. **What is a CBCT Scan:** A CBCT scan, also called cone beam computerized tomography, is a three-dimensional x-ray technique that is like medical CT scans. CBCT scans are primarily used to visualize bony structures and teeth, not soft tissues such as your tongue and gums.

2. **Advantages of a CBCT scan**: CBCT examinations provide a 3D image, which may be used for the diagnosis and treatment planning, for endodontic treatment, dental implants and surgery. By using a CBCT, we have an enhanced ability to understand conditions that can be missed on a conventional x-ray.

3. **Radiation risks:** CBCT scans, like conventional x-rays, expose you to radiation. There are certain inherent and potential risks from x-rays. The dose is approximately the same as the following U.S. background radiation dose equivalents: 1 day for upper teeth, 3 days for lower front teeth and 5 days for lower back teeth. An alternative to a CBCT scan are conventional dental x-rays, however, they have the limitations previously noted.

4. **Women:** CBCT scans are generally NOT recommended for pregnant women because of possible danger to the fetus.

Initial as appropriate
_____ I am not pregnant
_____ I am pregnant
_____ I am unsure whether I am pregnant

5. **Diagnosis of non-dental conditions**: While parts of your anatomy beyond your mouth and jaw may be seen on the scan, we are neither physicians nor radiologists and will not make assessments concerning your anatomy beyond your mouth or jaw. If the report raises a question as to something unusual outside the specific area of your mouth or jaw, we may refer you to a physician or radiologist for an evaluation. In such an event, our office can place the image on a CD. You should also understand that CBCT scans cannot be relied upon to show soft tissue lesions, unless they have caused changes in your hard tissues (teeth or bone). Also, CBCT images may contain artifacts that can make interpretation difficult.

DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT, UNDERSTAND IT AND AGREE WITH WHAT IT SAYS

I certify that I have read this consent form and that I understand the procedure to be performed, and its benefits, risks and alternatives. I acknowledge that I have had a full opportunity to discuss this procedure with Drs. Kirsh, Lichstrahl or their designee or Associates, and have had any/all questions answered to my satisfaction. Thus, I give my informed consent to Drs. Kirsh, Lichstrahl and/or their Associates or designated staff to perform the CBCT scan.

Patient Signature: **X** _____ _____
(If under 18 years old, parent or legal guardian; relationship to patient): _____ Date

Print Name: _____ Assistant Signature: _____

FOR OFFICE USE ONLY (Preliminary Medical Codes):

G89.11	Acute Pain Due to Trauma
G89.18	Acute Postoperative Pain, Other
G50.1	Atypical Facial Pain
J33.0	Polyp of nasal cavity
J33.1	Polypoid sinus degeneration
J33.8	Other polyp of sinus
J33.9	Unspecified nasal polyp
J32.0	Chronic maxillary sinusitis
J32.8	Other chronic sinusitis
J32.9	Unspecified sinusitis (chronic)
K02.9	Dental caries, unspecified
K02.61	Dental caries limited to enamel
K02.62	Dental caries extending into dentine
K02.63	Dental caries extending to pulp
K02.7	Dental caries of smooth surface
K02.9	Dental caries of root surface
K03.3	Other dental caries
K03.3	Pathological resorption, unspecified
K03.3	Pathological resorption, internal
K03.3	Pathological resorption, external
K03.3	Other pathological resorption
K03.4	Hypercementosis
K03.5	Ankylosis of teeth
K03.7	Intrinsic post-eruptive color changes
K03.81	Cracked tooth
K03.89	Other diseases of hard tissues of teeth
K03.9	Unspecified disease of hard tissues of teeth
K04.0	Pulpitis
K04.1	Necrosis of the pulp
K04.2	Pulp degeneration
K04.3	Abnormal hard tissue formation in pulp
K04.4	Acute apical periodontitis of pulpal origin
K04.7	Periapical abscess without sinus
K04.5	Chronic apical periodontitis
K04.6	Periapical abscess with sinus
K04.8	Radicular cyst
K04.90	Other and unspecified diseases of pulp and periapical tissues
K02.9	Dental caries, unspecified