



# PENINSULA ENDODONTICS DENTAL GROUP

KINGSTONE C. SHIH, DDS  
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## PATIENT INFORMATION (PLEASE PRINT):

Dr.  Mr.  Mrs.  Ms. (First Name) \_\_\_\_\_ (M.I.) \_\_\_\_\_ (Last Name) \_\_\_\_\_

Date of Birth (MM/DD/YY) \_\_\_\_\_ Social Security # \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Address:

Street: \_\_\_\_\_ Apt. # \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Mobile # \_\_\_\_\_

### Billing address if different from above

Street: \_\_\_\_\_ Apt. # \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

General Dentist's Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_ Phone # \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Have you or a family member been treated in our office before?  Yes  No

If yes, with which one of our doctors? \_\_\_\_\_

### IN CASE OF EMERGENCY:

PLEASE CONTACT: \_\_\_\_\_ Phone # \_\_\_\_\_

### DENTAL INSURANCE INFORMATION:

*If you have dental insurance and would like us to submit the claim on your behalf, please provide the following information:*

Name of Subscriber: \_\_\_\_\_ Name of Employer: \_\_\_\_\_

Subscriber's ID# \_\_\_\_\_ Subscriber's Date of Birth (MM/DD/YY) \_\_\_\_\_  
(May be SSN)

Relationship to Employee: (please circle one) SELF SPOUSE/PARTNER CHILD

Name of Insurance Company: \_\_\_\_\_ Group # \_\_\_\_\_

Street: \_\_\_\_\_ Suite # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_ Phone # \_\_\_\_\_

.....  
If you have SECONDARY dental insurance, please provide the following information:

Name of Subscriber: \_\_\_\_\_ Name of Employer: \_\_\_\_\_

Subscriber's ID# \_\_\_\_\_ Subscriber's Date of Birth (MM/DD/YY) \_\_\_\_\_  
(May be SSN)

Relationship to Employee: (please circle one) SELF SPOUSE/PARTNER CHILD

Name of Insurance Company: \_\_\_\_\_ Group # \_\_\_\_\_

Street: \_\_\_\_\_ Suite # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zipcode: \_\_\_\_\_ Phone # \_\_\_\_\_

## PATIENT HEALTH HISTORY

General Dentist's Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Are you presently under a physician's care for a current illness or condition?  Yes  No

List any drugs you are currently taking: \_\_\_\_\_

List any herbal supplements you are currently taking: \_\_\_\_\_

Have you ever or are you now taking any of the following? (please circle) Zometa, Aredia, Fosamax, Actonel, Didronel, Skelid, Boniva, Bonefos, or Osteoc?

Do you take aspirin daily?  Yes  No

Have you been treated for alcoholism or drug addiction?  Yes  No

### DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (Please Circle)

Diabetes Yes No   If yes, how is it controlled?  Diet  Medication

Heart Surgery/Stroke Yes No   Date of Surgery/Stroke: \_\_\_\_\_

Heart Murmur Yes No

Heart Disease/Angina Yes No

Rheumatic Fever Yes No

Mitral Valve Prolapse Yes No

Pacemaker Yes No

Artificial Valve Yes No

High Blood Pressure Yes No

Kidney Disease Yes No

Anemia Yes No

Peptic/Duodenal Ulcer Yes No

Bleeding/Hemophilia Yes No

Artificial Joint/Prosthesis Yes No

Hepatitis Yes No   Which type? \_\_\_\_\_

Asthma/Emphysema Yes No

Epilepsy Yes No

Tuberculosis Yes No

Nervous Disorder Yes No

Cancer/Tumor Yes No

Arthritis Yes No

Chronic Sinus Yes No

Chronic Depression Yes No

Fainting/Dizziness Yes No

Thyroid Yes No

TMJ Disorder Yes No

Chronic Headaches Yes No

Chemotherapy/Radiation Therapy Yes No

Immunodeficiencies Yes No Date \_\_\_\_\_

Is there anything else in your health history of which we should be aware? Please explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DO YOU PRESENTLY HAVE A TOOTHACHE?  YES  NO

HAVE YOU EVER HAD ROOT CANAL TREATMENT?  YES  NO

Is any part of your mouth sensitive to the following:

Hot	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cold	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Biting/Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Primary complaint \_\_\_\_\_

Have you ever had an adverse reaction to local anesthetics?  Yes  No

ARE YOU ALLERGIC TO ANY MEDICATION OR ANTIBIOTICS (PENICILLIN, ETC.)?  YES  NO

ARE YOU ALLERGIC TO LATEX OR ANYTHING ELSE THAT WE SHOULD KNOW ABOUT?  YES  NO

PLEASE LIST \_\_\_\_\_

OTHER ALLERGIES? \_\_\_\_\_

**WOMEN ONLY:**

Are you taking any birth control medication?  Yes  No

**NOTE: ANTIBIOTICS MAY INTERFERE WITH THE EFFECTIVENESS OF ORAL CONTRACEPTIVES.**

Are you or could you be **PREGNANT**?  Yes  No

If you are pregnant, in what month are you of your pregnancy? \_\_\_\_\_

I, the undersigned (patient or legally responsible party), consent to the dental treatment decided upon to be necessary by the Dentist and myself. I further authorize the taking of radiographs and/or other diagnostic measures appropriate for a thorough evaluation. I understand that if any change occurs in my health I am to report it to the dental office as soon as possible. I have read and understand each question, and have answered all of them truthfully and to the best of my ability. I understand upon completion of root canal therapy in this office, I **MUST RETURN TO MY GENERAL DENTIST FOR PERMANENT RESTORATION.**

Signature of Patient (Parent or Guardian if minor): \_\_\_\_\_ Date \_\_\_\_\_



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### INFORMATION ABOUT ENDODONTIC TREATMENT

#### WHAT ARE MY ALTERNATIVES?

Endodontic treatment has been recommended as a procedure to be done on your tooth in an attempt to retain a tooth that may otherwise require extraction. Your alternatives to the proposed treatment are to have no treatment done or to have the tooth extracted. If no treatment is done, there is the risk of infection, pain and loss of the tooth. If the tooth is extracted, then some form of an artificial replacement tooth may be constructed.

#### WHAT ARE THE POSSIBLE COMPLICATIONS?

Complications **are rare**. While no complications may be expected as a result of the proposed endodontic treatment, it is possible that complications may still occur with your care. Most of the complications that can occur are a normal consequence of treating teeth that have problems similar to yours. These complications may require additional treatment.

Some of the possible complications include, but are not necessarily limited to, the following possibilities: mild to severe pain, infection, swelling, fever, difficulty opening or closing the jaw, fractures, access complications, calcified canals or separated instruments. There is also a possible risk of loss of sensation (numbness) which could be either temporary or permanent.

Endodontic treatment is a highly successful procedure for retaining teeth that would otherwise be extracted. Unfortunately, not all teeth will respond favorably to the treatment. Consequently, it is possible that your tooth may in the future require additional treatment such as another endodontic treatment, surgery, or even extraction.

Medications may be given for pain or infection. If given pain medication, you should not drive an automobile nor operate equipment that may be hazardous to yourself or others. If you are a female who is taking birth control pills, it is possible that you could become pregnant while taking an antibiotic. Consequently, an alternative form of contraception may be appropriate while taking the antibiotic.

**To protect your tooth from decaying or fracturing, you will need to return to your dentist for a permanent filling or crown.**

#### CONSENT FOR TREATMENT

I have read the above and I understand that no treatment is without some measure of risk and the risks of the proposed treatment have been explained to me. I prefer to undergo the ENDODONTIC (root canal) procedure in order to attempt to retain my tooth. Consequently, I hereby authorize the Doctors and their assistants to perform the necessary endodontic procedures which have been described to me. I further request and authorize them to do whatever they deem advisable and necessary as a result of unforeseen circumstances.

Signed (Patient/Legal Guardian): \_\_\_\_\_

Date: \_\_\_\_\_