Welcome!

Connecticut Endodontics
Rick Morant, DMD, MS

PATIENT INTAKE FORM

Today's Date:_____
Patient Name: _____ SSN: _____ Sex: M F
Address: _____ City: _____ State: _____ Zip: _____
Home #: _____ Cell#: _____ Age: _____ DOB: _____ ☐ Married ☐ Single
General Dentist: _____ **Referred By** (if other than dentist): _____

Please fill out information below for the Person Finiancially Responsible for this account.
☐ Self ☐ Other (name): _____ Relationship:_____SSN: _____
Address: _____ City: _____ State: _____ Zip: _____
Home #: _____ Cell#: _____ Age: _____ DOB: _____ ☐ Married ☐ Single
Employer: _____ Address: _____ Work #:_____
Driver's License #: _____ Email: _____

INSURANCE

Name of Subscriber:_____DOB:_____ SSN: _____ Sex: M F
Primary Insurance Co: _____Phone #: _____ Payor ID: _____
Claims Mailing Address: PO Box_____City:_____State: _____ Zip: _____
Employer: _____ Subscriber ID:_____ Group #:_____

ACKNOWLEDGEMENT OF CONNECITCUT ENDODONTICS, LLC FINANCIAL POLICY

I understand that I am responsible for payment for all treatment received and also understand that if I have insurance, it will be filed as a courtesy to me. I understand that insurance pre-estimates are not a guarantee of payment. I also authorize my insurance company to issue payment directly to Connecticut Endodontics, LLC, and/or Rick Morant, DMD, MS.

Print Name of Patient/Gaurdian:_____**Signature :** _____ **Date:**_____

MEDICAL HISTORY

Reason for today's visit: _____Estimation of your general health?_____
Preferred Pharmacy/location:_____ Pharmacy Phone#:_____
Are you **allergic** to any medications? ☐ No ☐ Yes (list) _____
Please list ALL medications you are taking at this time:_____

Do you have or have you ever had any of the following?

☐ No ☐ Yes Heart Disease	☐ No ☐ Yes Glaucoma	☐ No ☐ Yes Stomach Ulcers
☐ No ☐ Yes Heart Attack	☐ No ☐ Yes Diabetes	☐ No ☐ Yes Kidney Problems
☐ No ☐ Yes Heart Murmur	☐ No ☐ Yes Anemia	☐ No ☐ Yes Cancer
☐ No ☐ Yes High Blood Pressure	☐ No ☐ Yes Bleeding Problems	☐ No ☐ Yes Radiation/Chemo
☐ No ☐ Yes Rheumatic Fever	☐ No ☐ Yes Systemic Lupus	☐ No ☐ Yes Psychiatric Care
☐ No ☐ Yes Mitral Valve Prolaps	☐ No ☐ Yes Hepatitis	☐ No ☐ Yes Fainting Tendency
☐ No ☐ Yes Shortness of Breath	☐ No ☐ Yes Thyroid Disease	☐ No ☐ Yes HIV/AIDS
☐ No ☐ Yes Chest Pains	☐ No ☐ Yes Tuberculosis	☐ No ☐ Yes Treatment w/ Steroid
☐ No ☐ Yes Sinus Problems	☐ No ☐ Yes Severe Headaches	☐ No ☐ Yes Organ Transplant
☐ No ☐ Yes Lung Problem/Asthma	☐ No ☐ Yes Seizures	☐ No ☐ Yes Liver Problem/Jaundice
☐ **No ☐ Yes Hip/Joint Replacement**	☐ **No ☐ Yes Takes Pre-Med**	☐ **No ☐ Yes Latex/Rubber Allergy**

Please list any other medical problems not listed above: _____

☐ No ☐ Yes **I am currently under a pysician's care for a medical condition.** (please describe)_____
Physicians Name:_____Phone #:_____
☐ No ☐ Yes **I have been hospitalized withing the past year.** If yes, what was the reason?_____
☐ No ☐ Yes **I take bisphosphonates.** (Osteoporosis medication)
☐ No ☐ Yes **I am anxious about being here today.**
☐ No ☐ Yes **I have previously had a root canal.**
☐ No ☐ Yes **I am currently pregnant.** How many weeks?_____
☐ No ☐ Yes **I am currently breast feeding.**
☐ No ☐ Yes **Are you taking birth control pills.** (Antibiotics may decrease the effectiveness.)

ACKNOWLEDGEMENT OF RECEIPT OF THE HIPPA NOTICE OF PRIVACY AND FINANCIAL POLICY OF CONNECTICUT ENDODONTICS, LLC

☐ *I hereby acknowledge that I have read/requested a copy of the office HIPPA Notice of Privacy Policy.*
☐ *I have been given the opportunity to ask questions regarding this policy and give* ***Connecticut Endodontics, LLC*** *permission to send my information to my General Dentist/Specialist, Medical Physician, and/or my Insurance Company if it is requested.*
☐ *I have read/accept* ***Connecticut Endodontics, LLC Financial Policy*** *and Understand that I am responsible for any unpaid balance.*

Print Name of Patient/Gaurdian:_____**Signature :** _____ **Date:**_____

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INFORMED CONSENT

This document signed and dated, is my consent for **Connecticut Endodontics, LLC** to perform any dental treatment deemed necessary in an attempt to preserve my tooth with root canal therapy. This document will allow **Dr. Rick Morant** to perform a diagnosis, administer local anesthesia, and perform root canal therapy and any other necessary post-operative care needed.

Root canal treatment is the procedure of cleaning and filling the inside of a tooth that has become diseased or infected. Your treatment may take more than one visit. and you may experiance some soreness and discomfort in and around the tooth being treated. Root canal treatment may allow the tooth to remain in the mouth for many years, if not a lifetime.

Although root canal therapy has a high degree of sucess, it is still a biological procedure and it has been explained to me that a perfect result cannot be guaranteed or warranted. I have been informed that there are certain uncontrollable risks that can arise which can lead to further treatment being necessary. Som of these potential risks include, but are not limited to the following:

- ☐ Fracture of existing tooth structure, fillings, crowns, and bridges may occur.
- ☐ Short term muscle and jaw pain.
- ☐ Temporary or permanent numbness of lip or face from anesthesia or surgery.
- ☐ Extremely calcified, curved or previously treated canals can increase the difficulty of treament causing canal blockage, ledging, root perforation, or broken instruments.
- ☐ Post-operative pain, swelling and/or infection.
- ☐ Overfills or underfills of gutta percha and/or sealer.
- ☐ Multi-focal pain may require treatment of more than a single tooth to alleviate pain.

The other treatments, which could be necessary include, but are not limited to the following: retreatment, surgery, root removal, or even extraction.

I also understand that some teeth may have fractures in them, which can lead to eventual extraction of the tooth although they are not detectable at the time of treament. Most fractures that are in the clinical crown of the tooth are easily restorable with root canal therapy and a **full coverage crown** restoration. Fractures that extend to the root portion of the tooth may or may not be detectable at time of treatment and can eventually lead to continued chewing pain and eventual extraction.

Once your root canal therapy has been completed, **it is your reponsibility to see your dentist in a timely manner (within 4 weeks after treatment) and have the tooth permanently restored.** Failing to have the tooth restored in a timely manner could lead to recomtamination of the root canal filling material and subsequent infection with the possible need for retreament at the patient's expense.

I have been given the opportunity to question the doctor concerning the nature and inherent risks of the treatment described as:

_____

_____

_____

Print Name of Patient/Gaurdian:_____

Signature : _____ **Date:**_____

Print Name of Witness:_____

Signature : _____ **Date:**_____