KERR ENDODONTICS

WELCOME TO OUR PRACTICE

PATIENT INFORMATION

Title: ☐ Mr ☐ Mrs ☐ Ms First Name: M.I.: Last Name:

Sex: ☐ M ☐ F Birth Date: Age: Soc. Sec. #:

Street Address: Apt/Ste:

City: State: Zip:

Home Phone: Cell Phone: E-mail:

Referred By: General Dentist:

Medical Doctor: Preferred Pharmacy:

Emergency Contact: Relation: Phone:

ACCOUNT RESPONSIBILITY

Who will be responsible for your account? ☐ Self ☐ Father ☐ Mother ☐ Other

Guarantor Name: Phone:

Street Address: Apt/Ste:

City: State: Zip: Employer:

DENTAL INSURANCE INFORMATION

Primary Dental Insurance

Insured Party Name:

Relation: Sex: ☐ M ☐ F

Birth Date: SS #:

Address:

Employer: Bus. Tel:

Ins. Co. Name: I.D. #:

Group #: Group Name:

Secondary Dental Insurance

Insured Party Name:

Relation: Sex: ☐ M ☐ F

Birth Date: SS #:

Address:

Employer: Bus. Tel:

Ins. Co. Name: I.D. #:

Group #: Group Name:

DENTAL INFORMATION

Please indicate any of the following problems by checking off the corresponding box:

- ☐ Discomfort, clicking, popping jaw
- ☐ Difficulty closing jaw
- ☐ Locking jaw
- ☐ Ringing in ears
- ☐ Blisters/sores in/around mouth
- ☐ Burning tongue / lips
- ☐ Swelling/lumps in mouth
- ☐ Lost/broken filling(s)
- ☐ Red, swollen, bleeding gums
- ☐ Difficulty opening jaw
- ☐ Bad breath
- ☐ Broken/chipped tooth
- ☐ Prolonged bleeding from injury
- ☐ Toothache
- ☐ Stained teeth
- ☐ Teeth grinding/clenching
- ☐ Removable dental appliance
- ☐ Loose/shifting teeth
- ☐ Food caught between teeth
- ☐ Gum disease
- ☐ Recent infections / sore throat

Teeth sensitive to: ☐ Hot ☐ Cold ☐ Sweets ☐ Biting

Other:

Patient Acknowledgement: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.

Signature of Patient, Parent, or Guardian: Date:

KERR ENDODONTICS

SPECIALTY PATIENT MEDICAL & DENTAL HEALTH HISTORY

PATIENT FULL NAME: _____ **DOB:** _____ **DATE:** _____ **HEIGHT:** _____ **WEIGHT:** _____

1. GENERAL HEALTH & HISTORY

1. Are you in good health? YES ☐ NO ☐
2. Are you currently under the care of a physician? YES ☐ NO ☐
3. Has a physician or previous dentist recommended antibiotics prior to dental/endodontic treatment? *(e.g., joint replacement, artificial heart valve, etc.)* YES ☐ NO ☐
4. Have you had any major illness, operation, or hospitalization in the past five years? YES ☐ NO ☐
5. Have you ever had general anesthesia, or had serious/unusual reactions to it (you or family)? YES ☐ NO ☐

2. MEDICAL CONDITIONS & HISTORY

- ☐ Rheumatic Fever
- ☐ High Blood Pressure
- ☐ Heart Attack/Angina
- ☐ Chest Pain / Pressure
- ☐ Heart Surgery/Pacemaker
- ☐ Irregular Heartbeat
- ☐ Mitral Valve Prolapse
- ☐ Diabetes/Low Blood Sugar
- ☐ Hepatitis/Mononucleosis
- ☐ Hay Fever/Sinus Trouble
- ☐ Arthritis/Joint Disease
- ☐ Low Blood Pressure
- ☐ Emphysema/COPD
- ☐ Respiratory Problems
- ☐ Damaged Heart Valves
- ☐ Tuberculosis/Cough
- ☐ Immune System Problems
- ☐ Jaundice/Liver Disease
- ☐ Abnormal/Heavy Bleeding
- ☐ Kidney Trouble / Dialysis
- ☐ Gallbladder Trouble
- ☐ Blood Transfusion/Disorder
- ☐ Snoring/Sleep Apnea
- ☐ Fainting Spells / Seizures
- ☐ Asthma/Bronchitis
- ☐ Stroke/TIA
- ☐ Thyroid Trouble
- ☐ Contagious Diseases
- ☐ Bleeding Tendency / Anemia
- ☐ Stomach Ulcers/Reflux
- ☐ Prosthetic Joint/Implant
- ☐ COVID-19 Complications
- ☐ Swollen Ankles / Edema
- ☐ GI Troubles/IBS/Colitis
- ☐ Osteoporosis / Osteonecrosis
- ☐ Eye Disease/Glaucoma
- ☐ Tumor or Abnormal Growth
- ☐ Cancer/Chemotherapy
- ☐ Trouble Climbing Stairs
- ☐ Chronic Fatigue/Sweats
- ☐ Mental Health Conditions
- ☐ Contact Lenses
- ☐ Sexually Transmitted Disease

3. LIFESTYLE & SUBSTANCE HISTORY

- ☐ Tobacco/Vape Use (Amount/day: _____)
- ☐ Chewing Tobacco Use
- ☐ Currently on Special Diet / Restricted Diet
- ☐ History of Alcohol Use Treatment
- ☐ History/Treatment for Marijuana or Substance Use

4. MEDICATIONS & ALLERGIES (EXPANDED FOR SPECIALTY CARE)

MEDICATION TYPES CURRENTLY TAKEN:

- ☐ Nerve Pills/ Tranquilizers
- ☐ Muscle Relaxers
- ☐ Diet Pills/Stimulants
- ☐ Blood Thinners (Aspirin, Eliquis, etc.)
- ☐ Pain Killers (incl. Aspirin)
- ☐ Antidepressants
- ☐ Insulin/Diabetes Meds
- ☐ Bone Density/Bisphosphonates

PRESCRIPTION & OTC MEDICATIONS/SUPPLEMENTS (List all current medications):

Medication/Supplement Name	Dosage	Frequency

ALLERGIES & DRUG REACTIONS:

- ☐ Penicillin/Amoxicillin
- ☐ Sulfa Drugs
- ☐ Local Anesthetics
- ☐ Aspirin
- ☐ Codeine/Narcotics
- ☐ Soy/Eggs/Sulfites
- ☐ Latex/Rubber
- ☐ Sedatives/Valium

ADDITIONAL ALLERGIES / OTHER REACTIONS (Write in any unlisted allergies):

Allergy/Substance Name	Reaction/Severity (e.g., Rash, Anaphylaxis, Nausea)

Other Antibiotic Allergies: _____ **Other Non-Drug Allergies:** _____

FOR WOMEN ONLY: Antibiotics may alter birth control effectiveness. ☐ Pregnant (Due Date: _____) ☐ Nursing ☐ Birth Control Pills

5. PATIENT ACKNOWLEDGMENT

I certify that I have read and understand the above information to the best of my knowledge. Questions have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my health.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN:

_____ DATE: _____

KERR ENDODONTICS

Patient Consent, Acknowledgment & Financial Agreement

Patient Name:

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 doctor, 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 permit the office to communicate with me via text message on my cell phone.

X

Signature of patient (Parent or Guardian if Minor) Date

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

X

Signature of patient (Parent or Guardian if Minor) Date

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X

Signature of patient: (Parent or Guardian if Minor) Date

CONSENT TO TREAT & ENDODONTIC TREATMENT INFORMATION

Kerr Endodontics

Patient Name: _____ **DOB:** _____

I am giving my written consent for the provider to consult my case and/or administer the necessary dental services. I will be provided all necessary information and options regarding my condition so that I may better understand the treatment recommended and make an informed consent.

ENDODONTIC TREATMENT INFORMATION

Root canal treatment (also called endodontic treatment) requires removing the nerve and other tissues (called the pulp) from inside the tooth and its root(s). Once treatment is begun, it is absolutely necessary that the root canal treatment is completed. One or more appointments may be required to complete treatment. It is the patient's responsibility to seek attention if any extraordinary circumstances occur. The patient must follow any and all pre/post-operative instructions given to them. If you are given any prescriptions, you must take them as directed and in entirety. Failure to do so could compromise the success of the procedure. Following root canal treatment, the tooth will need a final restorative procedure by your dentist. The tooth may also require additional treatment called crown lengthening. These procedures are a separate cost and performed by a periodontist or your general dentist. If you fail to have the tooth restored, you risk failure of the root canal treatment success and possible loss of the tooth. It is the patient's responsibility to make additional appointments for the final restorative work within two weeks of the completed treatment in our office.

ALTERNATIVES TO ROOT CANAL TREATMENT

The alternatives to root canal treatment include: **EXTRACTION**. **EXTRACTION** may be followed by replacement with an artificial tooth by means of a fixed bridge, removable partial denture, or by dental implant. **NO TREATMENT** is also an option but carries associated risks not limited to serious personal injury, including severe pain, localized infection, loss of the tooth and adjacent teeth issues, severe swelling, and/or severe infection that may be potentially fatal.

RISKS

I UNDERSTAND THAT ROOT CANAL THERAPY includes but is not limited to such possible inherent risks as the following:

1. **Pain or Discomfort:** Swelling, bleeding, changes in bite, injuries to adjacent teeth, loosening or loss of dental restorations, new infection, or worsening of existing infection in the treated tooth or surrounding area. These risks may be evident both during and after completed treatment.
2. **Other Risks include:** Perforation of the tooth, root, or sinus, injury to soft tissues of adjacent teeth, nerve disturbances resulting in temporary or permanent numbness, itching, burning/tingling of lip, tongue, chin, teeth and/or mouth tissues. Adverse reactions to anesthetic injection, treatment tools and/or solutions used during treatment; Discomfort to jaw from holding mouth open during treatment; Failure of existing restorations or crowns when drilled through for endodontic treatment access that may require replacement.
3. **Instrument Separation:** Sometimes the small, fragile instruments used in root canal treatment separate inside the canal. This may necessitate either sealing the instrument inside the root, apical surgery or extraction of the tooth.
4. **Root Canal Therapy Alone Is Not Always Successful:** Many factors contribute to success and not all factors can be determined in advance, if ever. Resistance to infection, specific bacteria causing infection, adequate gum attachment and bone support, oral hygiene, previous dental care, general health, size, shape and location of the canals, blocked, curved, or narrow canals, undetectable root fractures or failure for unexplained reasons are some of these factors. No matter how well treatment has been rendered, there is a possibility of failure and consequent extraction.

ACKNOWLEDGMENT AND CONSENT

I have provided Dr. Mark A. Kerr and associates a complete and accurate Medical and Personal History including medication allergies and use. I will be given the opportunity to ask any questions regarding the nature, purpose of root canal treatment and receive answers to my satisfaction. I voluntarily assume any and all possible risks, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved and no guarantees have been made to me concerning those results. By signing this form, I am freely giving my consent to allow and authorize the treating provider to render any and all recommended treatment advisable to my dental condition, including any and all anesthetics and/or medications and x-rays. I further agree to follow any and all pre and/or post-operative instructions given.

_____ _____

Patient Signature **Date**

Notice: To improve efficiency, this office may use AI-assisted technology to help prepare clinical notes, reports, and other documentation. All records are reviewed for accuracy and approved by the treating provider or authorized staff.

KERR ENDODONTICS

Acknowledgement of Receipt of Notice of Privacy Practices & Consent to Release Personal Health Information

Our practice is committed to securing the privacy of your health information. A copy of our notice of privacy practices is available at the office upon request. Please acknowledge that you have reviewed this document and agree to the release of your personal health information to designees you list below. **Even if no designees are listed, we ask that you please sign, date, and print your name acknowledging your review of the document.**

I CONSENT TO THE RELEASE OF MY PERSONAL HEALTH INFORMATION TO:

Name	Relationship

I HAVE REVIEWED THE NOTICE OF PRIVACY PRACTICES:

Signature _____ Please Print Name _____ Date _____

FOR OFFICE USE ONLY

We attempted to obtain written Acknowledgement of Receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

1. Individual refused to sign.
2. Communication barriers prohibited obtaining the acknowledgement.
3. An emergency situation prevented us from obtaining acknowledgement.
4. Other - Specify: _____

Employee Name _____ Name of Dentist _____ Employee Signature _____ Date _____