

I, RICHARD MASSOTH, DDS
LISE LAFLAMME, DMD, INC.
ENDODONTICS

Patient: (first name) (initial) (last name) (birth date)
Home Address: (street) (city) (zip) (code)

Home Phone: Cell Pager
Patient (parent) Employed By: Business Phone:
Business Address: Spouse Employed By:

Occupation: Business Phone:
Name of Spouse: Spouse Employed By:
Business Address: Business Phone:

Physician's Name: Phone:
Person responsible for account: Dr. Lic. #
Name of Dental Ins.: Soc. Sec. #
Email: _____

HEALTH HISTORY

- | | YES | NO |
|---|-------|-------|
| 1. Are you in good health? | _____ | _____ |
| 2. Have you been treated by a physician during the past five years? | _____ | _____ |
| 3. Are you taking any medications now? (Aspirin, Birth Control Pills, etc.) | _____ | _____ |
| 4. Are you sensitive or allergic to novocaine, codeine, any other medications or latex products? | _____ | _____ |
| 5. Have you ever had an unfavorable reaction to local anesthetic? | _____ | _____ |
| 6. Have you ever had excessive bleeding requiring special treatment? | _____ | _____ |
| 7. Have you ever had any of the following illnesses? If so please circle:
Stroke, heart trouble, high blood pressure, rheumatic fever, asthma, tuberculosis, hepatitis, jaundice, kidney disease, diabetes, epilepsy, nervous disorder, anemia, scarlet fever, fainting, dizzy spells, thyroid problems, venereal disease, AIDS, HIV(+)? | _____ | _____ |
| 8. Have you ever had any other serious illness? | _____ | _____ |
| 9. Have you ever been told that you have a heart murmur and/or mitral valve prolapse? | _____ | _____ |
| 10. Have you ever taken Fen Phen or Redux? | _____ | _____ |
| 11. Do you have any artificial valve, joints, or prostheses? | _____ | _____ |
| 12. Female patients: Are you pregnant? Which month? _____ | _____ | _____ |

PERMISSION FOR ROOT CANAL PROCEDURE

I understand that root canal treatment is an attempt to retain a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had a root canal therapy may require retreatment, surgery, or even extraction.

Date _____ Patient's/Parents Signature _____ Reviewed _____

I hereby authorize payment directly to the below-named dentist of the group insurance benefits otherwise payable to me

signed (insured person) _____ Date _____

I, RICHARD MASSOTH, DDS
LISE LAFLAMME, DMD, INC.
ENDODONTICS

Patient's Name _____ Date: _____

1. This is to certify that I consent and hereby authorize, and request the performance, upon myself, of the dental surgical procedure known as _____
2. I also authorize and request the administration of anesthetic(s), as may be deemed necessary or advisable by the doctor.

3. The success of root canal therapy is influenced by many factors. Your general health, adequate gum attachment and bone support, shape and condition of the roots and their canals, quality of previous dental care, and pre-existing root fractures, all affect individual healing.

4. The treated tooth may remain sensitive following appointments. If sensitivity persists and does not seem to be getting better please phone the office for an appointment. Usually, administration of an appropriate medication will quickly resolve the problem. It is normal for a treated tooth to be sensitive for one week after the final appointment and to feel different than the surrounding teeth for another two weeks.

5. In some teeth, regular root canal therapy alone may not be sufficient. If the canals are severely curved or calcified, if there is substantial infection in the bone around the roots, or if an instrument breaks and remains within a canal, the tooth may remain sensitive and an endodontic surgery procedure may be necessary to resolve the problem.

6. Root fracture is one of the main reasons why root canal therapy fails. Unfortunately, some cracks that extend from the crown down into the roots are invisible and undetectable. They can occur on uncrowned teeth from traumatic injury, biting on hard objects, habitual clenching or grinding, and even just normal wear and tear. Whether the fracture occurs before or after the root canal, it will probably still require extraction.

7. I acknowledge the above procedure to be advisable or necessary, and that the doctor has explained the nature of the procedure to me, in terms which I understand, and has answered questions I have asked to my satisfaction.

8. The doctor has also explained alternatives to the above treatment (including no treatment).

9. I further acknowledge that I have been informed of the possible significant risks and complications involved during or after the performance of the treatment rendered including: (patient please check those explained by the doctor)
 post-operative pain, swelling, bleeding.
 infection and/or prolonged healing.
 temporary or prolonged numbness, 'tingling' or burning (or altered sensation) of the lip, chin, tongue, gums, or teeth.
 permanent crowns and bridges may be damaged or fall off necessitating replacement.

10. I fully understand that dental medicine and surgery is not an exact science and that a precise outcome or perfect result cannot be guaranteed. I hereby authorize Dr. _____ to proceed with treatment.

Signed: _____

Witness: _____