Dr. H. Lance Donald, DDS & Daniel J. Cassis, DDS
Practice Limited to Endodontics

106 Professional Dr.
West Monroe, La. 71291

Name________________ Home Phone ________ Bus. Phone________ Cell Phone________

Mailing Address________________ City, State________________ Zip________

Physical Address________________ City, State________________ Zip________

Date of Birth________________ Social Security________________

Employer________________ Employer Phone________________

Parent or Spouse's Name________________ DOB ________ Parent or Spouse's Social Security ________

Parent or Spouse's Employer________________ Spouse's Employers Phone________________

Referring Dentist ________________ Emergency Contact________________ Phone________________

Dental Insurance Carrier________________ Group Number________________

Policyholder ________________ Relationship to Patient________________

Employer of the Policyholder ________________ Social Security ________________

Date of Birth of the Policyholder ________________ Member's ID Number________________

Physicians Name________________ Phone________________

Are you now or have you recently been under a physician's care? ________________

Date of last physical________________

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

() * Heart Transplant
() * Heart Valve Repair
() * Artificial Heart Valve
() * History of Endocarditis
() * Congenital Heart Disease
___ Unrepaired or incompletely repaired cyanotic congenital heart disease, including those with palliative shunts or conduits
___ A completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first six months after the procedure.
___ Any repaired congenital heart defect with residual defect at the site or adjacent to the site or a prosthetic patch or prosthetic device.
() * Surgically Constructed Shunts/Conduits
() * Dialysis Shunts
() * Artifical Joint
() Abnormal Heart Condition (Type)_______
() Heart Surgery (Date & Type)
() Heart Pace Maker (Date) ______
() Chest Pain
() Heart Attack (Date) _________
() Cardiac Stents Via Catheter

() Stroke (Date) ____________
() High Blood Pressure
() Hemophilia or Bleeding Disorder
() Stomach Ulcer
() Epilepsy or Seizures
() Fainting Spells
() Neurological Disorder
() Cancer/Tumor/Malignancy (Type) ______
() Chemotherapy (Date) ________
() Radiation Therapy (Date) _______
() Thyroid Disease
() Liver Disease
() Lung Disease

() Tuberculosis
() Asthma or Hay Fever
() Insulin Dependent Diabetic
() Non Insulin Dependent Diabetic
() Kidney or Bladder Trouble
() Immune Deficiency
() Anemia
() Drug or Alcohol Addiction
() Hepatitis A, B, or C
() Glaucoma
() Sinus Trouble
() Latex Allergy
() Sleep Apnea

Any other Medical Conditions that are not listed above?________________

Have you taken Bisphosphonates or any bone density inducing drugs? (Examples are Boniva, Actonel, & Fosamax) () Yes or () No

If answer is Yes, Name of drug and how long taken:________________

List drug allergies if any:________________

List medications you are currently taking, if any________________

____

Chief complaint (what dental problems have resulted in your referral to this office?)________________

Women only: Are your pregnant?________________ How many months? ________ Are you breast feeding? ________

Are your presently taking birth control pills or hormones? ________________

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge.

Signature________________________________ Date________________

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Anesthesia Consent Form

Tooth _______

Patient's Name **Date**

Please *initial* **after reading the following definitions:**

_____ Nitrous Oxide with Local Anesthesia: Nitrous Oxide (or Laughing Gas) helps to lessen uncomfortable sensations and offer some relaxation.

_____ Oral Premedication with Nitrous Oxide: A pill taken for relaxation prior to giving local anesthesia.

Whichever technique you choose, giving any medication involves certain risks. These include:

1: Nausea and Vomiting
2: An allergic or unexpected reaction. If an allergic reaction is severe, it might cause more serious breathing or heart problems which may need treatment.

Fortunately, these complications and side effects are not common. All forms of Anesthesia are generally very safe, comfortable, and easy to deal with. **If you have any questions, please ask.**

I have read and give my consent for the following checked service:

_____ Nitrous Oxide/Oxygen Analgesia with Local Anesthesia
_____ Oral Premedication with Local Anesthesia

Female Patients Only, please initial: ____ I hereby consent that I am not pregnant.

Consent

I understand that my doctor can't promise that everything will be perfect. I have read and understand that the above and give my consent to surgery. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before signing this form.

Patient's (or Legal Guardian's) Name **Date**

Doctor's Signature **Date**

Witness' Signature **Date**

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CONSENT TO PERFORM ENDODONTICS

I understand that root canal treatment is a procedure to retain a tooth which may otherwise require extraction. In general terms, root canal treatment is the procedure in which diseased tissue is removed from inside the tooth. The root canal is cleaned, shaped, sterilized, filed and sealed to prevent further infection and/or loss of the tooth. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed.

I, the undersigned, have been informed that if I require an endodontic procedure (root canal treatment) I fully understand the following:

1. Failure to follow this recommendation will most likely result in
    a. The loss of the tooth.
    b. Bone destruction due to an abcess.
    c. Possible systemic (affecting the whole body) infection.
2. A certain percentage (5 to 10 percent) of root canals fail, and thereby may require retreatment, periapical surgery or even extraction.
3. During instrumentation of the tooth an instrument may break and lodge permanently in the tooth or an instrument may perforate the root wall. Although this occurs rarely, such an occurrence could cause the failure of the root canal and the loss of the tooth.
4. When making an access (opening) through an existing crown or placing a rubber dam clamp, damage could occur and a new crown would be necessary after endodontic therapy.
5. Successful completion of the root canal procedure does not prevent future decay or fracture.
6. **The permanent restoration (crown, bridge, etc.) if indicated will be completed by my general dentist in order to preserve the potential success of the root canal treatment and the function of the tooth. Failure to do so may result in root fracture and expedite the loss of the tooth.**
7. Teeth which have had root canal treatment started or completed previously may be more difficult and have a different outcome than expected under optimal conditions.
8. Additional possible complications include but are not limited to the following:
    a. procedural difficulties in the course of treatment.
    b. Swelling, soreness, infection, trismus (difficulty opening mouth) or discoloration of adjacent tissues.
    c. Complications following anesthesia (bruising, numbness, swelling or allergic reaction)

All treatment will be performed in strict accordance with accepted methods of clinical practice. **Included will be the taking of a minimum of two or three x-rays for each tooth requiring root canal treatment.** My signature below serves as evidence that I have read and understand or received explanation from the doctor regarding the content of this form and thereby give consent for the performance of root canal treatment on the patient indicated.

______________________________ ____________________
Patient or Patient's Guardian Date

______________________________ ____________________
Witness to Signature Date

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PATIENT CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physical certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to my signing this consent that has been displayed in the reception area of this practice.. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ____

Signature: ____

Relationship to Patient:_____________________________________

Date: ____