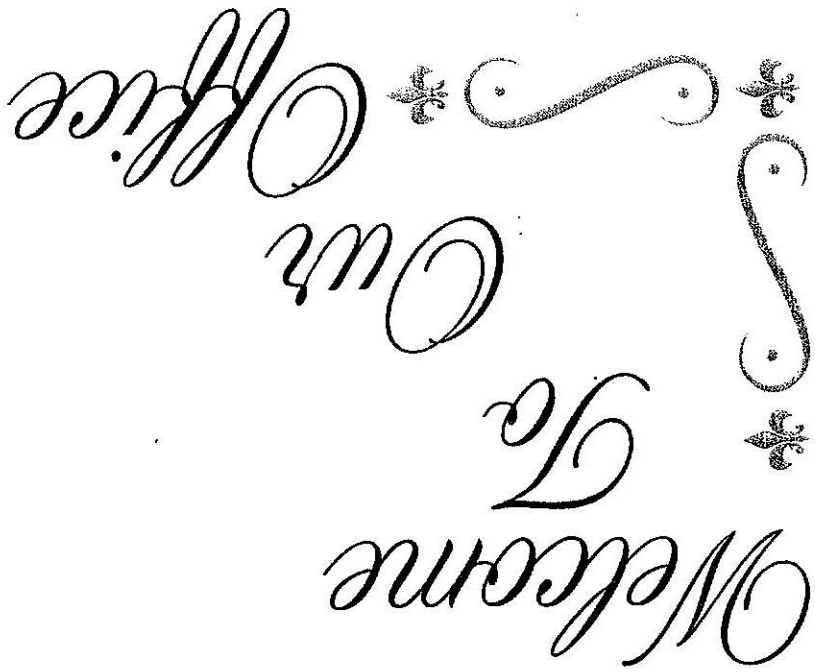

ENDODONTIC INFORMED CONSENT

You have been referred for Root Canal Treatment. This is a procedure to try to save a tooth that otherwise requires extraction. Like any biological procedure, there are no guaranties of any kind. If the canals in the tooth are calcified with severe curvatures it can prevent the complete removal of bacteria or cause the instruments to break in the canals, making removal impossible.

The material used to fill the canals could be extruded outside the canal and can create some sensitivity in the area. All this could require an additional surgical procedure or an extraction.

A crown lengthening procedure might be necessary to restore your tooth. That should be determined by your general dentist not us, since we do not do restoration of teeth.

This procedure will require local anesthesia to be used. In the lower teeth paresthesia or numbness of the lip or side of the tongue could occur, this is usually a temporary condition lasting months, but it could be permanent.

If any of the above occurs and the tooth needs to be extracted; no monies will be refunded, since we spend a lot of time and effort doing this procedure and we have expenses also.

After treatment is completed, if the temporary filling is lost and the tooth becomes re-infected due to contamination it will result in re-treatment at your expense. You need to have tooth restored as soon as possible (within 1 month).

I certify that I have read and understood the above. I give consent to Dr. Ruiz for all the necessary treatment to be performed.

Print Name _____ Signature _____ Date _____

Patient's Name _____ Birthday _____

Name of Parent (if child) _____ Birthday _____

Name of Spouse _____ Birthday _____

Residence Address _____

City/State/Zip _____ SS# _____

Phone _____ Cell _____ Work _____

Employer's Name _____

Address _____

Spouse or Parent Employed by _____

Address _____ Occupation _____

Dental Insurance _____ Group# _____

Referred Name: _____ Dentist ❑ Other ❑

Physician's Name _____

Are you under the care of a physician Yes ❑ No ❑ Reason: _____

Date of Last Physical Examination _____ Reason _____

Please check the appropriate box.

	Yes	No
Nose obstruction	❑	❑
Heart or chest pain	❑	❑
Herpes	❑	❑
Hepatitis Type____ Year____	❑	❑
Diabetes	❑	❑
Heart Murmer	❑	❑
Mitral Valve Prolapse	❑	❑
High Blood Pressure	❑	❑
Kidney Disease	❑	❑
Liver Disease	❑	❑
Lung Disease	❑	❑
Asthma	❑	❑
Rheumatic fever	❑	❑
Convulsions	❑	❑

	Yes	No
Hip/Knee Replacement	❑	❑
HIV Positive	❑	❑
Anemia	❑	❑
Allergy to:		
Penicillin	❑	❑
Sulfa	❑	❑
Local Anesthetic	❑	❑
Codeine	❑	❑
Aspirin	❑	❑
Barbiturates (sleeping pills)	❑	❑
Latex	❑	❑
Allergy to other drugs	❑	❑
Are you Pregnant?	❑	❑

Other Condition _____

Are you now taking medicine of any kind? Yes ❑ No ❑ List: _____

Have you ever responded unfavorably to medical or dental care? Yes ❑ No ❑

Remark: _____

Date: _____ Signature: _____

HISTORY CHART Review by _____ Title or Relationship _____

ENDODONTICS & PERIODONTICS ASSOC., PA

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A:
PATIENT GIVING CONSENT

NAME (Patient)_____Date of Birth: Month._____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, a physician providing treatment to you, healthcare operations in case of a incapacity or emergency situation, if we believe you are a victim of Domestic violence or the possible victims of other crimes, to the proper authorities.

Family member or Friends: We may use or disclose your health information to a family member or another person that you agree we may do so: Yes___No___ if Yes,

Full Name:_____Relationship to you_____.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

ENDODONTICS & PERIODONTICS ASSOC., PA., CROWN POINTE PROFESSIONAL CENTER

4244 W. LINEBAUGH AVE. TAMPA, Fl 33624-Telephone # (813) 960-9080

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment; payment activities and heath care operations.

(Signature) I_____Date:_____,

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

TO BE FILLED ONLY IF YOU ARE A REPRESENTATIVE IN BEHALF OF A PATIENT

Personal Representative's Name (PRINT)_____Date of Birth:_____

Patient's name_____Birthdate_____

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include completed Consent in the patient's chart.

Signature_____Date_____

FILL ONLY IF YOU ARE REVOKING CONSENT: REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my consent.

Signature:_____Date:_____ >>>>>>>OVER>>>