JEFFREY C. KOTZ, D.M.D., P.A.

PLEASE PRINT Date: ____________

First MI Last

Patient Name: ____

Street Address: ____

City/State: ______________________________ Zip Code: ____________

Cell Phone: (____) ____________ Home (____) ____________ Work (____) ____________

Date of Birth: ___/___/___ SS#: ______________ Drivers License #: ______________

Employer: ________________ Address: ______________________

Referred by: ____

Person Responsible for Account (if different than above):

Name: ____

Street Address: ____

City/State: ______________________________ Zip Code: ____________

Cell Phone: (____) ____________ Home (____) ____________ Work (____) ____________

Employer: ______________________ Relation to patient: ______________

SS#: ____________________ Drivers License #: ____________________

DENTAL INSURANCE*

*Please note: If you have Dental Insurance, you are responsible for any portion not covered by your insurance. This non-covered portion will be due at the time of service. If for any reason the insurance company does not cover this procedure or your insurance coverage ends during treatment, you will be responsible for any outstanding balance that has not been paid.

Insurance Company Name: ____________________________________
Insurance Company Street Address: ____________________________
City/State: ____________________ Zip: __________ Phone: (____) ________
Group Number: ____________________ Subscriber Number: ______________
NAME OF POLICY HOLDER: ____________________ Date of Birth: ___/___/___
SS#: ____________________ Relation to patient: ____________________
POLICY HOLDER Address (if different than patient): ____________________
POLICY HOLDER employed by: ____________________________________
Address: ______________ City/State/Zip: ______________ Work Phone (____) ________

MEDICAL HISTORY

1. Your current physical health is (circle one): GOOD FAIR POOR

2. Are you currently under the care of a physician? YES NO
   IF YES, please explain:____

3. Are you taking any prescription or over-the-counter drugs? YES NO
   IF YES, please list each one:____
   ____

4. Please circle any of the following if you currently have or ever had in the past:

Rheumatic Fever	Endocarditis	Total Joint Replacement (e.g. artificial knee or hip)	Hepatitis	Anemia
Kidney Disease	Diabetes	Liver Disease	High Blood Pressure	Sinusitis
Glaucoma	Blood Disease	Epilepsy	AIDS/HIV positive	Artificial heart valves
Heart Transplant	Heart Disease	Other:		

5. Have you ever had, or do you currently have Osteoporosis? YES NO
   IF YES, please list any drugs you have ever taken in the past ***or*** are currently taking for Osteoporosis:
   ____

6. Have you ever had Multiple Myeloma? YES NO
   IF YES, please list any drugs you have ever taken in the past ***or*** are currently taking for Multiple Myeloma:
   ____

7. Have you received any donor organs, artificial heart valves, or joint implants? YES NO

8. Have you ever had trouble with prolonged bleeding after surgery? YES NO

9. Are you ***allergic to*** any of the following (if yes, please circle)?

Latex	Aspirin	Ibuprofen	Tylenol	Codeine	Dental Anesthetics	Penicillin	Clindamycin

10. Please list any other drugs or materials that you are allergic to:____________________________

11. Is there any other information that should be known about your health or about previous dental visits?
    ____

12. FOR WOMEN: Are you pregnant? YES NO Week #:______
    Are you nursing? YES NO

INFORMED CONSENT

I have read and understand the information letter “To Our Patients” and hereby give consent to treatment:

PRINT: ______________________________SIGN:_______________________________________
DATE:_______________________________

Jeffrey C. Kotz, D.M.D., P.A

Practice Limited to Endodontics

TO OUR PATIENTS:

Some Patients may be apprehensive and anxious about root canal treatment. In order to avoid any misunderstanding and to better inform you, the following information and office policies are provided for your benefit:

1. Endodontics, or root canal therapy, is that specialty of dentistry devoted to the saving of teeth where the pulp (nerve) is affected. It is true that it is easier to extract a tooth than to save it, but the value of a natural tooth is irreplaceable. In Addition, extraction and replacement is usually more costly.

2. No tooth will be undertaken for treatment unless there is an excellent chance for success. While there is no absolute certainty concerning the healing of body tissues, we expect it to occur in approximately 95% of the cases. Should the success rate for saving your tooth be estimated to be below this average, you will be so informed.

3. Complete treatment averages two visits. First, a small opening is made in the biting surface of the tooth, then the pulp tissue is removed and the canal or canals are cleaned out, shaped, and medicated. The tooth is closed with a white temporary filling material. At the time of the final visit, the canal or canals are sealed with a rubber-like material called gutta percha and again the opening is filled with a temporary filling material.

4. Root canal therapy assumes certain inherent risks, including but not limited to: fracture of the tooth or an existing porcelain restoration ("cap"), tooth perforation, and instrument separation. While the incidence of these complications is extremely low, their occurrence might necessitate additional procedures.

5. Generally you can expect treatments to be fairly simple...similar to having a filling done. The manipulation of the tooth during treatment may produce some minor irritation and you may have some tenderness for one or two days following appointments. Medication taken for a headache, or that prescribed by our office, should control this minor discomfort. In some rare instances, a tooth that was comfortable before the beginning of the treatment can manifest severe pain and swelling after a treatment session known as a "flare up". (If you experience a flare up, please call us.)

6. Between treatments there will be a temporary filling in the tooth. *Do not chew on that side of your mouth.* This will allow for faster healing, less discomfort, and prevent accidental breakage of the temporary filling. Please maintain normal hygiene.

7. When root canal treatment is completed, your tooth will require a permanent restoration, either a filling or a crown (to be decided by your referring dentist). Our fee does not include this procedure. Your general dentist will render this service which is essential for the preservation of your tooth. Please schedule an appointment with him or her as soon as possible after your last appointment with us.

PATIENT NAME (please print): ______________________________

PATIENT SIGNATURE: ______________________________

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