JOSEPH A. SILVAGGIO, DMD
KRISTIN M. JABBS, DMD
BILAL CHAUDHRY, DMD

PLEASE ANSWER EACH AND EVERY QUESTION ON THE front and back sides of this form. IT IS **IMPORTANT** TO **INCLUDE** all information we are requesting, especially **MEDICATIONS, VITAMINS AND SUPPLEMENTS** you may be taking at this time.

DATE:_____

Patient
Name: _____

Address: _____

City:_____ State:_____

Zip:_____ Sex:_____ Marital Status:_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Social Security No.:_____

Birth Date:_____ Age:_____

Occupation: _____

Employer: _____

General Dentist: _____

Who referred you? _____

Have you ever been treated by our doctors?_____

PLEASE READ THE FOLLOWING CAREFULLY:

The information contained on this form is correct, to the best of my knowledge. I agree to be responsible for all fees related to my visits here, including any returned check charges, as displayed. I allow release of all of my information to my dentists/doctors, as required by them.

Signature:_____
(If patient is a minor, parent/guardian must sign)

Parent/Guardian Info for minors under 18 yrs old:

Name: _____

Soc. Sec. No: _____ Birth Date:_____

Phone/Address if different from minor's: _____

_____

****

PLEASE FILL IN EACH SECTION with your DENTAL INSURANCE

PRIMARY CARRIER:

Insurance Carrier Name:_____

Employer: _____

ID #/Soc. Sec. #: _____

If Subscriber is *NOT* the patient, please fill in:

Subscriber Name: _____

Subscriber Address: _____

Subscriber ID#/Soc. Sec.#: _____

Subscriber Date of Birth: _____

Relationship to Patient:_____

If Patient is a Full-Time College Student:

College: _____

College City & State: _____

SECONDARY CARRIER:

Insurance Carrier Name:_____

Employer: _____

Subscriber Name: _____

Subscriber Address: _____

Subscriber ID #/Soc. Sec. #: _____

Subscriber Date of Birth: _____

Relationship to Patient:_____

PLEASE **CIRCLE** ANY OF THE FOLLOWING WHICH YOU **HAVE** OR **HAVE HAD** IN THE PAST:

Heart Trouble	Heart Murmur	Mitral Valve Prolapse	
Rheumatic Fever	Angina	High Blood Pressure	
Epilepsy	Asthma	Paget's Disease	Low Blood Pressure
Stroke	TIA	Multiple Myeloma	Congenital Heart Disease
Diabetes	Anemia	Osteogenesis Imperfection	Thyroid Disease
Tuberculosis	Arthritis	Primary Hyperparathyroidism	
Lung Disease	Radiation Treatment	Convulsions	
Herpes	Hepatitis A B or C	Glaucoma	
Psychiatric Treatment	Ulcer	Kidney Disorder	
Migraine	Sinus Conditions	Blood Disorders	Fainting Spells
Venereal Disease	MS	Breast Cancer/Mastectomy	
Osteoporosis	Other: _____		

PLEASE **CIRCLE** ANY OF THE FOLLOWING TO WHICH YOU ARE **ALLERGIC** OR HAVE HAD AN **UNUSUAL REACTION** TO:

Latex	Novocaine	Xylocaine	
Epinephrine	Penicillin	Amoxicillin	Sulfa Drugs
Motrin	Valium	Aspirin	
Codeine	Demerol	Sedatives	
Barbiturates	Erythromycin	Steroids	

Other: _____

GENERAL HEALTH:

1) Excellent Good Fair Poor

2) If you are under the care of a physician at this time for other than regular check-ups, please explain:

_____

Name of caring physician: _____

3) Do you need to premedicate prior to dental treatment?

_____

(It is necessary for some patients to take large dose antibiotics one hour prior to dental treatment, due to heart murmur, mitral valve prolapse or artificial joints.)

4) **LIST THE NAMES OF ALL** prescribed and non-prescribed **medications, vitamins, supplements and drugs you are taking today:** _____

_____

_____

_____

_____

_____

_____

5) Are you taking or have you taken **in the past 10 years any Bisphosphonates? (EX:** Actonel, Aldronate, Aredia, Boniva, Didronel, Fosamax, Reclast, Skellid, Zometa)
If yes, which one? _____

6) Are you wearing a pacemaker or heart valve prosthesis?

_____

7) If you have been hospitalized or had a serious illness in the past five years, please explain: _____

8) Have you ever been diagnosed as having **HIV** or **AIDS**? ____

9) Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma? _____

10) Are you pregnant?____ If so, how far along? _____

11) Have you ever undergone endodontic treatment (root canal therapy or apical surgery)? _____

12) What symptoms are you experiencing today?_____

_____

13) Is there any other information we should know about your health or teeth? _____

_____

SILVAGGIO ENDODONTICS
Joseph A. Silvaggio, DMD PC

INFORMED CONSENT FOR ENDODONTIC TREATMENT

(PA state law requires a consent form prior to endodontic treatment)

Before starting endodontic treatment (root canal therapy, apicoectomy, etc.), you should be informed of all risks and alternatives to endodontic treatment. You will be required to sign this consent prior to the initiation of treatment. However, it does not commit you to treatment. **This consent serves to acknowledge that you have been informed and understand the following.**

Endodontic treatment is an attempt to retain a tooth, which may otherwise require extraction. I understand that it is a process involving removal of tissues in the center of the tooth (the root canal) and the sealing of the space that is created during the process of removal and cleansing of the root canal system. I further understand that the root canal treatment may fail, if proper restoration of the tooth is not completed after the root canal treatment is done, and that such restoration is a separate and distinct procedure with an additional fee. *Although root canal therapy has a high degree of success, it cannot be guaranteed. The doctor will exact his professional training to achieve success and avoid or minimize complications listed below. Initial root canal treatment success can be as high as 90%. Occasionally, a tooth, which has had root canal therapy, may require retreatment, microsurgery, or extraction. Retreatment and surgical success rates are approximately 70%.*

The alternatives to endodontic treatment include no treatment, waiting for more definitive development of symptoms, and extraction of the tooth. I understand the risks of no treatment include, but are not limited to, infection, swelling, cyst formation, pain and loss of tooth/teeth and/or systemic disease.

Risks of endodontic treatment are of two kinds – those risks associated with general dental procedures (as in any dental office), and those risks specific to endodontic treatment (in this office).

Risks of general dental procedures include, but are not limited too, complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections. These complications include pain, infections, swelling, bleeding, sensitivity, numbness, and tingling sensation (transient or permanent) in the lips, tongue, chin, gums, cheek, and teeth, thrombophlebitis (inflammation to the vein), reaction to injections (including a temporary rapid heartbeat), change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth or restorations in teeth, injury to other tissues, referred pain to the ear, neck, and head, nausea, vomiting, allergic reactions, itching, bruises, delayed healing, sinus complications and further surgery. Prescribed medication and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol and other drugs). Therefore, it is advisable not to operate any vehicle or hazardous device, or to work for twenty-four hours or until recovered from their effects. Antibiotics may interfere with oral contraceptives and caution should be used during antibiotic use.

Risks specific to endodontic therapy include instruments broken within the root canal(s), perforations (extra openings) of the crown or root of the tooth, damages to bridges, existing fillings, crowns or porcelain veneers, loss of tooth structure in gaining access to canals and fracture of tooth structure, and change in tooth color (becoming darker than adjacent teeth). During treatment, complications may be discovered which make treatment impossible, or may require microsurgery, or extraction. These complications may include blocked or obstructed canals resulting from fillings, prior treatment, natural calcification, broken instruments, curved roots, periodontal disease (gum disease), and cracks or fractures of the teeth.

If you are scheduled for surgery, the risks specific to it involve an incision into the gingival tissue (gums). Any incision into the gums carries the inherent risks of swelling, bruising, scar formation, recession of the gum lines, numbness, which could be temporary or permanent, and possible infection. A surgical procedure (most commonly called an apicoectomy) may also involve the removal of infected bone tissue and root tip of the tooth/teeth. In addition to the risks mentioned above, further complications include, but are not limited to, post-operative pain, bleeding, swelling, infection, bruising of the gums and face, damage to adjacent teeth, temporary or permanent numbness or tingling of the lip, chin, tongue or other areas, and perforation into the sinuses.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. BY MY SIGNATURE BELOW, I CONSENT TO THE TREATMENT DESCRIBED IN THIS PAPER.

Patient's Signature: _____ Date: _____

(Parent/Guardian must sign, if patient is a minor)

Witness: _____ Date: _____

SILVAGGIO ENDODONTICS
Joseph A. Silvaggio, DMD PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Date _____

This acknowledgement of notice and consent authorizes Joseph A. Silvaggio, DMD, PC to use and disclose health information about you and your treatment, payment, and healthcare operations purposes. This practice has a "Notice of Privacy Practices," which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. ***Please ask at the front desk if you desire to read or obtain the full privacy notice.***

I, (print name) _____, am aware of and/or received a copy of this practice's "Notice of Privacy Practices" and authorize them to use and disclose health information for treatment, payment, and healthcare operations purposes consistent with its "Notice of Privacy Practices."

_____

Signature of Patient *(or parent/guardian if patient is a minor)*

_____ _____

Printed Name of Minor Patient **Relationship to Patient**

****

Please fill in the **EMERGENCY CONTACT PERSON.** Also fill in **ALL NAMES OF THOSE WITH WHOM WE CAN DISCUSS YOUR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.** It is not necessary to include your dentist/referring dentist, as it is understood that he/she would be included to receive your treatment, payment, or healthcare operations information.

Emergency Contact	Relationship to Patient	Phone Number
Responsible Party	Relationship to Patient	Phone Number
Responsible Party	Relationship to Patient	Phone Number
Responsible Party	Relationship to Patient	Phone Number

CAN WE CALL YOU OR LEAVE A MESSAGE FOR YOU AT THESE NUMBERS?
IF YES, please put an **"X"** on the line. If you fill in **"OTHER"**, specify the number and who we are calling.

Home _____ Answering Machine _____ Work / Voicemail _____

Cell / Cell Voicemail _____ Pager _____ Fax_____

Other – Specify_____ Other – Specify _____