Possible Risks Associated With SURGICAL Endodontic Treatment

All items listed on the previous page (#1 – #5) plus: possible shrinkage of the gum where the gum line meets existing artificial crowns. This is usually of no consequence in terms of oral health, but may change the appearance of these teeth if they can be seen during speaking or smiling.

ALTERNATIVES TO ENDODONTIC TREATMENT AND ASSOCIATED RISKS

1. Extraction of tooth. Risks include:
    a) loss of jaw support.
    b) drifting or tipping of adjacent teeth, leading to problems in chewing, gum disease, and pain or tenderness from the jaw hinge joint (TMJ).
    c) need for replacement of extracted tooth with an artificial one. Your dentist can discuss the risks and options of this procedure more fully with you.

2. Refusing treatment or waiting for further symptoms. Risks include:
    a) possible pain, swelling and persistence of the infection within the bone surrounding the affected tooth.
    b) formation of abscesses in the mouth.
    c) formation of cysts in the jawbone surrounding the affected tooth, and sometimes spreading to involve adjacent teeth.

Persistent delay in treatment may ultimately require loss of the tooth which otherwise might have been successfully treated and retained.

The foregoing has been a summary of the need for, and steps involved in endodontic treatment, including the risks involved and alternatives to treatment. Should you desire further information or clarification, please do not hesitate to ask.

I acknowledge the foregoing and understand its contents. I hereby give my consent to be examined and treated as necessary.

Signature _____

Date _____

PARENTAL CONSENT STATEMENT FOR MINORS

I hereby give my consent to endodontic treatment for _____
(minor patient)

Signature _____

Relationship to Patient _____

Date _____

ALEXANDER HAKIM D.M.D.
ENDODONTICS
11645 WILSHIRE BLVD. #1035 LOS ANGELES, CA. 90025

To our patients:

Please be advised that our office requires a 48-hour notice for appointment changes. If you need to cancel an appointment, please call at least one day before your scheduled appointment. Same-day cancellations and no shows are subject to $85.00 fee.

Read and acknowledged, signature _____

Date _____

OFFICE POLICY: PRIVATE PATIENT/ INSURED PATIENT

THE BEST DENTAL HEALTH SERVICES ARE BASED ON A FRIENDLY, MUTUAL UNDERSTANDING BETWEEN PROVIDER AND PATIENT. THIS OFFICE POLICY REQUIRES PAYMENT IN FULL AND OR ESTIMATED COPAY FOR ALL SERVICES RENDERED AT THE TIME OF VISIT ACCORDING TO VERIFICATION OF COVERAGE. WE WILL SUBMIT YOUR INSURANCE CLAIM, BUT SUBJECT TO STATE AND FEDERAL LAW, YOU ARE ULTIMATELY RESPONSIBLE FOR THE SERVICES PROVIDED. IN THE CASE OF INSURANCE AS A THIRD PARTY PAYER, FINANCIAL RESPONSIBILITY ON THE PART OF THE PATIENT MUST BE DETERMINED BEFORE TREATMENT. HOWEVER, THIS OFFICE CANNOT RENDER SERVICES ON THE ASSUMPTION THAT CHARGES WILL BE PAID BY THE INSURANCE COMPANY. I UNDERSTAND THAT DENTAL SERVICES FURNISHED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT FOR ALL SERVICES. A SERVICE CHARGE OF 1.5% PER MONTH WILL BE CHARGED ON THE UNPAID PRINCIPLE BALANCE ON ACCOUNT NOT PAID WITHIN 60 DAYS OF TREATMENT DATE. ASSIGNMENT OF INSURANCE: I AUTHORIZE THE PROVIDER TO RELEASE ANY INFORMATION REQUIRED TO PROCESS INSURANCE CLAIMS. TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS ARE TRUE AND CORRECT.

SIGNATURE OF PATIENT/INSURED

_____ DATE _____

DR. ALEXANDER HAKIM
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME: _____

ADDRESS: _____

TELEPHONE: _____ **SOCIAL SECURITY NUMBER:** _____

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

PURPOSE OF CONSENT: BY SIGNING THIS FORM YOU WILL CONSENT TO OUR USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS.

NOTICE OF PRIVACY PRACTICE: YOU HAVE TE 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.

CONTACT: ALEXANDER HAKIM, D.M.D

TELEPHONE: 11645 Wilshire Blvd. #1035 **FAX** _____

ADDRESS: Los Angeles, CA 90025

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.

PLEASE PRINT YOUR NAME:

_____ **, HAVE HAD FULL OPPURTUNITY 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 HEALTH CARE OPERATIONS.**

SIGNATURE: _____ **DATE:** _____

IF THIS CONSENT FORM IS SIGNED BY A PERSONAL REPRESENTATIVE ON BEHALF OF THE PATIENT, COMPLETE THE FOLLOWING:

REPRESENTATIVE'S NAME _____ **RELATION TO PATIENT** _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
INCLUDE COMPLETE CONSENT IN THE PATIENTS CHART

ALEXANDER HAKIM, D.M.D.

PATIENT INFORMATION AND HEALTH HISTORY

Name _____ Date of Birth _____

Home Address _____ City _____ Zip _____

Soc. Security No. _____ Driver's Lic. No. _____ Mobile _____

Marital Status _____ Name of Spouse _____ Home _____

Patient's Occupation _____ Firm _____

Business Address _____ Telephone _____

Spouse's Occupation _____ Firm _____

Business Address _____ Telephone _____

Referred by _____ Emergency Contact

Patient's Dentist _____ Name & Number _____

How long have you been a patient of your present dentist? _____

Name of Dental Insurance Company (if any) _____

MEDICAL HISTORY

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes No Is your general health good?
   If NO, explain _____
2. Yes No Has there been a change in your health within the last year?
   If YES, explain _____
3. Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain _____
4. Yes No Are you being treated by a physician now? If YES, explain _____
   Date of last medical exam? _____ Reason for exam _____
5. Yes No Have you had problems with prior dental treatment?
   If YES, explain _____
2. Yes No Are you in pain now?
   If YES, explain _____

II. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING (Please Circle)

Chest Pain (Angina)
Fainting spells
Recent significant weight loss
Fever
Night sweats
Persistent cough
Coughing up blood
Bleeding problems
Blood in urine
Blood in stools
Diarrhea or constipation
Frequent urination
Difficulty urinating
Ringing in ears
Headaches
Dizziness
Blurred vision
Bruise easily
Frequent vomiting
Jaundice
Dry mouth
Excessive thirst
Difficulty swallowing
Swollen ankles
Joint pain or stiffness
Shortness of breath
Sinus problems

Women: Do you have any of the following conditions? (check box)

❑ Pregnancy ❑ Birth Control Pills ❑ Menopause ❑ Nursing ❑ Menstrual Problems

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 root canal therapy may require retreatment, surgery, or even extraction.

Signature: _____ Date: _____

III. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING (Please Circle)

Heart disease
Family history of heart disease
Heart attack
Artificial joint
Stomach problems or ulcers
Pacemaker
Heart murmurs
Rheumatic fever
Skin disease
Hardening of arteries
High blood pressure
Seizures
Cosmetic surgery

AIDS/HIV
Surgeries
TMJ
Diabetes
Family history of diabetes
Tumors or cancer
Chemotherapy
Radiation
Arthritis, rheumatism
Emphysema or other lung disease
Kidney or bladder disease
Stroke
Psychiatric care

Osteoporosis
Thyroid disease
Asthma
Hepatitis
Sexually transmitted disease
Herpes
Canker or cold sores
Anemia
Liver disease
Eye disease
Transplants
Tuberculosis
Others _____

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING (Please Circle)

Aspirin
Darvon
Codeine
Local anesthetic (Novacaine or Xylocaine)
Nitrous oxide
Sulfa Drugs

Valium
Demerol
Penicillin
Latex
Erythromycin
Others _____

Tetracycline
Vicodin
Percodan
Food
Metal

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please Circle)

Recreational Drugs
Over-the-counter medicines
Weight loss medications

Tobacco in any form
Alcohol
Bisphosphonate (Fosamax)

Antibiotics
Supplements
Aspirin

VI. PLEASE LIST ANY ADDITIONAL MEDICATIONS: _____

VII. ALL PATIENTS

Yes No Do you have or have had any other diseases or medical problems NOT listed on this form?
If YES, please explain: _____
_____

Yes No Have you ever been pre-medicated for dental treatment? If YES, why _____

Yes No Have you ever taken Fen-Phen? If YES, when _____

Yes No Is there any issue or condition that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Futher, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature of Patient (Parent or Guardian) **Date** **Signature of Dentist** **Date**