ALEXANDER HAKIM, D.M.D.
ENDODONTICS

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PATIENT INFORMATION AND CONSENT FOR EXAMINATION AND TREATMENT

Outline of Treatment

All treatment involves a preliminary diagnostic evaluation and consultation. Root canal therapy is performed in an attempt to retain a tooth which otherwise might require extraction. Treatment generally takes place over several visits, and is usually performed through an opening in the crown of the tooth. Occasionally, it must be done through an opening in the gum tissue adjacent to the tooth.

Although root canal therapy enjoys a high degree of success, no guarantee can be given. In each case, we are depending upon a response from nature to the procedure. In some cases, a tooth may require retreatment or even extraction. Factors that influence a successful result include the health of the supporting tissue, the anatomy of the root canal system, the degree of calcification, and the integrity of the tooth itself. Some cases require the use of medications as well as laboratory tests.

Following completion of root canal therapy, you must return to your dentist for placement of the appropriate restoration for the treated tooth. This should be done as soon as possible after treatment in order to protect the tooth from subsequent fracture and/or decay.

It is advised that you return to our office in a specified time following treatment for a follow-up examination to assess long-term healing.

Some Possible Risks Associated With Endodontic Treatment

As with dental treatment in general, endodontic treatment carries potential risks. Complications occur infrequently, however, every effort will be made to prevent their appearance and achieve the desired result. Some possible risks are:

1. Unanticipated or unpredictable reactions from anesthetics or medications used in connection with treatment.
2. A tingling or numb-like sensation in a localized area of the lips, tongue, mouth, or chin, which persists after the dental anesthetic has worn off. This condition is usually temporary and normal feeling will gradually return to the affected area. This process may take from several days up to several months or even years in unusual cases.
3. Tenderness, soreness, and/or swelling for a limited period, usually 1–3 days, following treatments. After completion of treatment, any tenderness still present will gradually diminish with time. Appropriate medication will be used as necessary to prevent or eliminate any discomfort.
4. Hairline fractures within the roots of the tooth, as well as fractures, cracks, or breaks in the crown of the tooth. These may be present prior to, occur during the course of, or following treatment. Predictability for successful treatment in these teeth is limited and uncertain. Decisions regarding initiation or completion of treatment must be based on a case by case basis.
5. Fracture, chipping, or dislodgement of permanently cemented porcelain jackets ("caps"), porcelain and gold crowns, inlays/onlays, gold crowns or bridges during treatment. Should this occur, your dentist must be consulted as soon as possible regarding his or her treatment of choice to be done following completion of endodontic therapy.

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 bonesurrounding 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 _____

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.
ENDODONTICS
11645 WILSHIRE BLVD. #1035 LOS ANGELES, CA. 90025

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES OF HEALTH HISTORY	DR'S INITIALS

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** _____