Jason O. Smith, D.M.D., M.S.

Patient Name:

Please mark "yes" or "no" to indicate if you have had any of the following:

Condition		Condition		Condition	
AIDS/HIV	☐Yes ☐No	Epilepsy	☐Yes ☐No	Respiratory Disease	☐Yes ☐No
Anemia	☐Yes ☐No	Fainting or dizziness	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Arthritis	☐Yes ☐No	Glaucoma	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Artificial Heart Valves	☐Yes ☐No	Headaches	☐Yes ☐No	Shortness of Breath	☐Yes ☐No
Artificial Joints	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Sinus Trouble	☐Yes ☐No
Asthma	☐Yes ☐No	Heart Problems	☐Yes ☐No	Special Diet	☐Yes ☐No
Bleeding abnormally, with extraction or surgery	☐Yes ☐No	Hepatitis	☐Yes ☐No	Stroke	☐Yes ☐No
Blood Disease	☐Yes ☐No	Herpes	☐Yes ☐No	Swollen Feet or Ankles	☐Yes ☐No
Cancer	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Swollen Neck Glands	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Jaundice	☐Yes ☐No	Thyroid Problems	☐Yes ☐No
Circulatory	☐Yes ☐No	Jaw Pain	☐Yes ☐No	Tonsillitis	☐Yes ☐No
Congenital Heart Lesions	☐Yes ☐No	Kidney Disease	☐Yes ☐No	Tuberculosis	☐Yes ☐No
CortisoneTreatments	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No	Tumor or growth on head or neck	☐Yes ☐No
Cough, persistent or bloody	☐Yes ☐No	Nervous Problems	☐Yes ☐No	Ulcer	☐Yes ☐No
Diabetes	☐Yes ☐No	Pacemaker	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Emphysema	☐Yes ☐No	Psychiatric Care	☐Yes ☐No	Weight Loss, Unexplained	☐Yes ☐No
		Radiation Treatment	☐Yes ☐No		

Are you currently taking or have you used Bisphosphonates (drugs used to treat osteoporosis and other bone loss-related issues) Yes ☐ No ☐

Have you ever taken any of the group of drugs collectively referred to as "Fen-Phen ? Yes ☐ No ☐

Women: Are you pregnant: Yes ☐ No ☐ Due Date:________________ Are you Nursing: Yes ☐ No ☐ Taking birth control pills: Yes ☐ No ☐

Medications:
List any medications you are currently taking and the correlating diagnosis: ____________________

Allergies:
Aspirin ☐ Barbiturates (sleeping pills) ☐ Codeine ☐ Iodine ☐ Latex ☐ Local Anesthetic ☐ Penicillin ☐ Sulfa ☐ Other ____________________

Patient Signature:____________________ **Date:** __________

Doctor's Signature: ____________________ **Date:**__________

Jason O. Smith D.M.D., M.S.

Informed Consent for Endodontic Treatment

Before we begin your treatment, we'd like you to know as much as possible about the risks which endodontic (root canal) therapy may pose and possible alternatives to endodontic treatment. You will be required to sign this consent prior to the initiation of the treatment however; it does not commit you to treatment. This consent serves to acknowledge that you have been informed and understand the following:

Root Canal 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 (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 do everything in his power to achieve success and avoid or minimizing complications listed below. Initial root canal treatment success can be as high as 90%. Occasionally, a tooth which has had root canal therapy may need retreatment, microsurgery or extraction. Retreatment and surgical rates are approximately 70% to 80%.*

Risks of endodontic treatment are of two kinds: those risks associated with general dental procedures (in any office) and those risks specific to endodontic treatment (in our office).

Risks of General Dental Procedures: Include (but are not limited to) complications resulting from the use of dental instruments, drugs sedation, medicines, analgesics (pain killers), anesthetics and injections. These complications may include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth; thrombophlebitis (inflammation to a vein), reaction to injections, change on 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, head, nausea, vomiting, allergic reactions, itching, bruises, delayed healing, sinus complications and further need for surgery. ***INITIALS*** _______

Medications: Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol and other drugs) thus, it is not advisable to operate any vehicle or hazardous device until recovered from the effects of the medication and drugs. Antibiotics may interfere with oral contraceptives and caution should used during antibiotic use. ***INITIALS*** _______

Risks More Specific to Endodontic Therapy: Include the possibility of instruments broken within the root canals; perforations (extra openings) of the crown or the root of the tooth; damage to bridges, crowns, existing fillings or porcelain veneers, loss of tooth structure in gaining access to the canals and fracture of tooth structure, and change in tooth color (becoming darker than adjacent teeth). During treatment, complications may be discovered which make endodontic treatment impossible, or which may require microsurgery or extraction. These complications may include blocked canals due to fillings or prior treatment, natural calcification, broken instruments, curved roots, periodontal (gum) disease, split or fractures of the teeth, chipping or loosening of existing tooth or crown. Although the endodontic treatment performed will be performed in a manner which will minimize and avoid risks and has a very high degree of clinical success, it is still a biological procedure and cannot be guaranteed. Occasionally a tooth that has had root canal therapy may require retreatment, surgery, or even extraction. ***INITIALS*** _______

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. ***INITIALS*** _______

Consent: I have carefully read and understand the above statements about root canal therapy; my questions have been answered to my satisfaction, and I give my consent to the treatment described in this paper.

____

Signature of Patient or Guardian (if patient is a minor)

Consent Form reviewed by: ____________________

Jason O. Smith D.M.D., M.S.

PATIENT REGISTRATION

Name ______________________/____/______________________ Sex: Male ☐ Female ☐

Home Address ______________________ Social Security # ______________

City ______________ ST _____ Zip ________ Birthdate ______________

Hm Ph# ______________ Cell # ______________ DL# ______________

Employer ______________________ Occupation ______________________

Business Phone # ______________ City ______________ ST_____ Zip ________

If Patient is a Minor ....

Parent/Legal Custodian Name ______________________ Home Phone# ______________

Home Address ______________________

City ______________ ST_____ Zip ________

Emergency Information

Emergency Contact ______________________ Relationship ______________

Address ______________________ Phone # ______________

Primary Insurance Information

Insured'sName______________________

Relationship to Patient Self ☐ Spouse ☐ Parent ☐

Insured's Social Security# ______________________

Insured's Birthdate ______________________

Insured's Employer ______________________

Dental Insurance ______________________

Group or Local # ______________________

Secondary Insurance Information

Insured's Name ______________________

Relationship to Patient Self ☐ Spouse ☐ Parent ☐

Insured's Social Security # ______________________

Insured's Birthdate ______________________

Insured's Employer ______________________

Dental Insurance ______________________

Group or Local # ______________________

Jason O. Smith, D.M.D., M.S.
2410 Sonoma St.. Ste. 2
Redding, CA 96001
(530) 243-2919

STATEMENT OF FINANCIAL RESPONSIBILTY

Insurance:

Payments are due at the time of treatment. Any co-payment calculated by our office is an **estimate** that is based on the information provided to us by your dental insurance provider and our past experience with that insurance provider. As a courtesy we will submit a claim for you, but filing an insurance claim for you does not relieve you of the responsibility of your bill. It is very important that you are aware of your insurance coverage as we are not responsible for any denials by dental plans. It is your responsibility to see that your insurance pays on time. If payment from your insurance company is not received within 60 days, your balance is then due in full.

Private Pay:

For those without dental insurance, we do require **payment in full at the time of service.** We do accept Visa, Mastercard, American Express and Discover. Monthly payment plans are available through **Care Credit**, please see our front office staff for information.

I, ______________________________, agree to pay for all services rendered by this office including any charges not paid by insurance.

______________________________ (Signature of patient of legal designate)

______________ Date

**** Please see our front desk for any questions you have before your treatment ****

JASON O. SMITH D.M.D., M.S.
2410 SONOMA ST., STE 2
REDDING, CA 96001

Acknowledgement

I have read the attached copy of the Jason O. Smith D.M.D., M.S. Notice of Privacy Practices.

____[Signature]

____[Date]

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name

Relationship to Patient ____

For Program Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)