OKLAHOMA ENDODONTICS
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Dennis A. Leseberg, D.D.S., M.S., Inc.
David B. Shadid, D.D.S., M.S.D., P.C.

Patient's Name____Resident phone ____________________
(PLEASE PRINT) (Last) (First) (Middle)
Mailing address__________________________________City____________________ State______ Zip________
Social Security No.____________________ Birthdate ____________________Cell phone ______________________
Patient / Parent employment____Bus. phone ____________________
Spouse's name____
Spouse's / Parent employment_______________________________________Bus. phone____________________
If patient is a minor give name of : Mother______________________________ Bus. phone ____________________
Father ______________________________ Bus. phone ____________________

DENTAL HISTORY

Dental complaint at the moment____
How recently have your teeth been cleaned? ____

CONFIDENTIAL HEALTH HISTORY

1. Referred by (General Dentist)___________________________ (Specialist)___________________________
2. Name of your medical doctor ____
3. Your general health is: Excellent________ Good________ Fair________ Poor________

	Yes	No	(Please elaborate on any YES answer)
4.	_____	_____	Have you recently been under the care of a physician?
5.	_____	_____	Have you had any previous unpleasant experiences with local anesthetic (Novocaine)?
6.	_____	_____	Are you allergic to any medications or materials? (List) ______________________________
7.	_____	_____	Do you take any medications? (List all Prescription and Nonprescription) ______________________________
8.	_____	_____	Do you suffer from shortness of breath or physical stress as you go about your daily activities?
9.	_____	_____	Are you diabetic?
10.	_____	_____	Have you had chest pains or swelling of the legs?
11.	_____	_____	Do you have a history of any heart disease, high blood pressure, or anemia?
12.	_____	_____	Do you have any bleeding tendencies?
13.	_____	_____	Have you had any liver disease, hepatitis, or jaundice?
14.	_____	_____	Do you have any disease of the thyroid gland?
15.	_____	_____	Do you have kidney disease or infections?
16.	_____	_____	Do you have any stomach problems?
17.	_____	_____	Have you had any severe emotional problems or psychiatric treatment?
18.	_____	_____	Do you presently have a venereal disease or history of AIDS?
19.	_____	_____	Are you a recovering medical dependent (drug addiction) or presently involved in a treatment program?
20.	_____	_____	Have you taken methamphetamine, cocaine, ecstasy, or any illegal drug, within the last 24 hours?
21.	_____	_____	Are you now or have you ever taken Bisphosphonates (Fosamax, Actonel, Boniva, Aredia, Zometa) for Osteoporosis, multiple myeloma or other cancers?
22.	_____	_____	Do you have a history of a prosthetic cardiac valve, previous infective endocarditis, congenital heart disease, cardiac transplant, or any artificial joints?
23.	_____	_____	Have you had any major health problem, extensive illness, hospitalization, or surgery that was not previously covered in the above questions?
24.	_____	_____	(Women) Are you pregnant or nursing?
25.	_____	_____	(Women) Are you currently taking birth control pills?

UD______ UD______ UD______ UD______ UD______ UD______ UD______ UD______ UD______ UD______

To avoid misunderstanding concerning payment of fees and to help our office staff assist you courteously and efficiently, please indicate which method of payment you prefer.

☐CASH ☐CHECK ☐CREDIT CARD

☐PAYMENT IN FULL ☐PARTIAL PAYMENT - file insurance, I understand that I am responsible for any unpaid amount.

____
SIGNATURE (Legally Responsible Person)

If you have dental insurance please fill in the following:

	Insurance Co.	Insurance Plan	Group No.	Employee	Employee SS#	Employee DOB
Primary	__________	__________	__________	__________	__________	__________
Secondary	__________	__________	__________	__________	__________	__________

Additional Info. ____

*Patients who carry Dental Insurance are reminded that professional services are provided and charged to the patient and not to the Insurance Company. Even though an insurance claim is filed, you will receive a statement each month if your account has a balance due. You are responsible for payment of your account within 45 days of treatment completion. Our office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim. If you have any questions we will be happy to assist you.

*Interest of 1.5% monthly (18% annually) will be assessed on any unpaid balance upon completion of treatment.

____
SIGNATURE (Legally Responsible Person)

I authorize payment of insurance benefits directly to provider.

RELEASE OF INFORMATION

I authorize release of any information regarding diagnosis and/or treatment to my referring dentist or insurance company.

Legally responsible person ____Date________________________

STATEMENT OF INFORMED CONSENT

I understand that root canal therapy is an attempt to save a tooth which would otherwise be extracted. Upon completion of my root canal treatment in this office, I am to return to my general dentist for restorative care, possibly including fillings or crowns (caps), which may be needed to protect my tooth.

I have agreed to treatment by Dennis A. Leseberg, D.D.S., M.S., and/or David B. Shadid, D.D.S., M.S.D., for an endodontic condition. The desirability of root canal therapy to retain my tooth, the method and manner of the proposed treatment, and the consequences of not having treatment have been explained to me. Other options include extraction and tooth replacement with a bridge, partial denture or implant. Although I understand that good results are expected, the possibility and nature of complications cannot be accurately anticipated and there can be no guarantees concerning the results of the treatment or the cure. In the event of non-healing (5-10%), the treatment may have to be redone, or root end surgery or extraction may be required. In cases of retreatment, the non-healing rate may be higher (20-30%).

Some risks known to be associated with dental procedures include, trismus (restrictive jaw opening), numbness, bleeding, discoloration, nausea, and allergic reactions. Risks more common to endodontic therapy include breakage of a metal instrument in the tooth, overextension of the filling material beyond the end of the root, blocked or calcified canals, perforation of the crown or root, tooth fracture, postoperative discomfort, swelling and infection. Treatment through crowns or fillings may result in irreversible damage to the crown or filling, or leakage with recurrent decay, which may require it to be replaced.

I have been informed of the possible risks and have had the opportunity to ask questions concerning the procedure to be performed upon me. I believe that I have received and understand sufficient information to give my consent to the treatment proposed and to allow the administration of any anesthetics and medications the doctor deems necessary for my care.

SIGNATURE (Patient / legally responsible person) ______________________________________Date______________________

THANK YOU