Medical History Form

Personal Information:

Salutation:	First Name:	Last Name:	M.I.
Home Phone:	Cell Phone:	Date of Birth:	
Work Phone:	Fax:	Gender:	
Home Address:	City/State/Zip:		
Employer Name:	Occupation:		
Employer Address:	Social Security #		
Referring Doctor	Family Dentist:		
Home E-mail:	Work E-mail:		
Dental Insurance Co:	ID#	Group#	
Insurance Claims Address:			
If you are a dependant of the subscriber			
Subscriber Name:	Subscribers Social Security #		
Subscribers DOB:	Subscriber Relationship:		

	Yes	No	Unknown
1. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth?			
2. Has There been any change in your health with in the past year? If yes, please explain:			
3. Are you under the care of a physician for a current problem? If yes, Please specify:			
4. Have you been hospitalized with in the past 5 years? If yes, please specify:			
5. Have you received therapy for alcoholism or drug addiction during the past 5 years?			
6. Have you ever had an ALLERGIC reaction ADVERSE REACTOINS to anesthetics/antibiotics/medications? Please specify:			
7. Is there any condition concerning your health that the doctor should e told? Please specify:			
8. Do you wish to speak with the doctor privately about anything?			
9. Have you had abnormal bleeding with previous extractions, surgeries or trauma?			
10. Have you ever required a blood transfusion?			
11. Have you ever had surgery and/or radiation for a tumor, growth, or other conditions?			
12. Have you ever tested positive for HIV infection or AIDS? If so, date diagnosed and the treating doctor:			
13. Are you required to take antibiotics prior to dental treatments?			

14. Have you had any of the following? If yes, please check the box below.

High Blood Pressure		Sinus Trouble	
Heart Murmur or prolapsed valve		Thyroid Problems	
Joint Prosthesis (hip, knee, etc.)		Diabetes	
Rheumatic Fever/Rheumatic heart Disease		Stomach Ulcers, Colitis	
Congenital Heart Disease		Hepatitis, Jaundice, Liver Disease	
Cardiovascular Disease		Kidney Problems	
Prosthetic Heart Valve		Psychiatric Treatment	
Blood Disorder (e.g., Anemia)		Fainting Spells or Seizers	
Venereal Disease		Epilepsy	
Asthma		Cancer	
Allergy to Latex		Temporomandibular Joint Problems	
Low Blood Pressure		Low Blood Sugar	

Chest Pain		Dialysis	
Swollen Ankles, Arthritis or Joint Disease		Irregular Heart Beat	
Cardiac Pacemaker		Contagious Disease	
Heart Surgery		Bronchitis, Chronis Cough	
Delay In Healing		Hay Fever or Sinus Problems	
Tuberculosis		Problems with Immune System	
Emphysema		Difficult Breathing or other lung issues	
X-ray treatment or Chemotherapy		Chronic Fatigue or Night Sweats	
On a diet		History of Drug Abuse	
History of alcohol abuse		Wear Contact Lenses	
Eye Disease or Glaucoma		Bruise Easily	
Infectious Mononucleosis		Gallbladder Trouble	

15. Are you taking any herbal medicine (i.e., St. Johns Wort)?			
16. Have you ever taken Fen-Phen?			
17. Do you have any disease, condition, or problem not listed above? Please specify:			
18. Are you taking any Medications or drugs? Is yes, please list them with times per day and milligrams.			

Women Only

Possibility of pregnancy?	Yes/No	Nursing?	Yes/No
Estimated Delivery Date:		Taking birth control pills?	Yes/No

NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of control.

If this visit is related to an injury, fill out the fields below

Accident Related		Work Related	
Date of Injury:		Claim Number:	
Insurance Company Handling Claim:			
Name of Attorney/Adjuster:			
Attorney/Adjuster Phone #:			

Physicians Info	Emergency Contact
Physicians Name:	Name:
Physicians Phone:	Work Phone:
Specialists Name:	Home Phone:
Specialists Phone:	

_____ _____.

Patient Signature (Parent Signature if patient is under the age of 18) Date

Pain History

	Yes	No	Unsure
1. Have you ever experienced pain in this tooth at any time in the past?			
2. Are you in Pain now?			
3. If you are in pain now, how long has it been? Please Circle One 1 Day, 2 Days, 3 Days, 4 Days, 5 Days, 6 Days, 1 Week, 2 Weeks, 3 Weeks			
4. Did this pain keep you awake or awaken you last night?			
5. Can you locate the tooth that is causing the pain?			
6. Does the pain radiate to other parts of your jaw or down your neck and shoulders?			
7. Is the pain Spontaneous or does it always require some stimulus to become painful?	Spontaneous		
	Requires Stimulus		
8a. Do you feel swollen?			
8b. Has there been any history of prior swelling?			
8c. Are you running a fever?			
9. How would you rate your severity of your pain today? 1-10 scale 1=very slight 10=Unbearable	1 2 3 4 5 6 7 8 9 10		
10. Do you have lingering pain? (More than a few seconds)			
11. Please describe the frequency and nature of pain that most closely describes your discomfort, by circling all those that apply.	Sharp, Dull, Radiating, Variable, Throbbing, Tingling, Constant, Migrating, Enlarging to other areas, Shooting, Itching, Aching, Intermittent, Momentary,Burning, Only when chewing or biting		
12. Is the tooth sensitive to temperature?			
13. What relieves the pain? Please circle all that apply.	Nothing, Cold, Hot, Massage, Vicodin, Non-Biting, Aspirin, Advil, Excedrin, Aleve, NSAIDS, Codeine, Antibiotics, Darvon, Other		
14. If you don't touch the tooth or bite on it, does it still hurt?			
15. What increases the pain? Please circle those that apply.	Touching, Biting, cold, hot, Eating, Cold Air, Lying Down, Pressing on the Gum, Flossing, Sweets, Nothing		
16. What is the course of the pain? Please circle those that apply.	Increasing, Decreasing, Constant, Variable, None		
17. Has there been any recent restorative work done on this area?			
18. Prior to this Appointment has any endodontic treatment been started by another doctor?			
19. Have you had recent periodontal (gum) surgery in the area or a tooth cleaning?			
20. Have you ever had endodontic surgery on this tooth?			
21. Are you numb now?			
22. Have you taken any antibiotics for this problem?			
23. Have you taken any pain killers for this problem?			
24. Did you explicitly request this referral?			
25. Did your doctor recommend this referral?			

L. Stephen Buchanan, DDS
Practice Limited to
Conventional & Microsurgical Endodontics
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Santa Barbara, CA 93101

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office 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)

_____

_____

_____

L. Stephen Buchanan, DDS, FICD, FACD

Practice Limited to Conventional and Microsurgical Endodontics
805.963.0370 / 805.963.0799 / practice@endobuchanan.com

INFORMATION AND CONSENT FORM

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

Root canal treatment is an attempt to retain a tooth that may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally, a tooth that has had root canal therapy may require retreatment, microsurgery, or extraction.

The alternatives to endodontic treatment include: no treatment, waiting for more definitive development of symptoms; and extraction of the tooth. Risks involved in these choices might include pain, swelling, infection, loss of tooth or teeth, and infection to other areas.

Risks of endodontic treatment are of two kinds: those risks associated with general dental procedures and those risks specific to endodontic treatment.

Risks of general dental procedures: Included (but not limited to) are 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, cheeks and teeth, thrombophleblitis (inflammation to the vein), reaction to injections, change in occlusion (biting), muscle cramps, 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, bruising, 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) thus, 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, so an alternative means of birth control should be planned for your entire cycle that month.

Risks specific to endodontic therapy: These risks 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. During treatment, complications may be discovered which make treatment impossible, or may require microsurgery. 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. It is suggested that when drilling through a porcelain crown, the crown be replaced due to micro fractures created during the drilling process. At times there may be complete fracture of the porcelain crown. Our office assumes no financial responsibility for the replacement of these crowns.

CT Scan: The CT-Scan used in our office is an excellent tool for the detection of infections associated with root canals, however it is not diagnostic for the detection of decay. Conventional radiographs should be taken at your dentist office for the detection of decay.

For those patients who have been referred to our office for a CT Scan only, a consultation with one of our doctors is not part of this appointment. Our office should be considered strictly as an imaging center. We do not review, diagnose, or render opinions to these patients. This is the responsibility of your referring doctor.

PLEASE SIGN IN THE SPACE BELOW UNLESS YOU HAVE QUESTIONS FOR THE DOCTOR.

If there is anything you do not understand about the endodontic procedure, or any statements in this form, or if you still have any questions after reading this form, please discuss them with the doctor before signing below. Thank you.

Signature _____ Date _____

Office Financial Policy

1. Payment Policy

   Payment is due upon arrival in our office before treatment is started. In addition to our normal cash or check services, we do offer Visa, MasterCard or Discover

2. Dental Insurance

   The payment you make at the time of service is **STRICTLY AN ESTIMATE.** Once your insurance company has paid, there may be an additional outstanding balance, which is due and payable by you. If your insurance company denies any part of your claim this shall be your responsibility.

3. Cancellation Policy

   Because your appointment time is reserved only for you, 48 hours is required in the event you need to cancel your appointment. Cancellations made with less than 48 hours notice will result in a $175 per hour cancellation fee per hour.(No cancellations will be accepted after 4:45pm on Fridays and throughout the weekend.)

I agree to financial policy:

Print name_____

Signature_____ Date_____

L. Stephen Buchanan, DDS, FICD, FACD

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LIVE PATIENT DEMONSTRATION CONSENT FORM

For Patients Participating in a Live Demonstration for the purposes of Dental Continuing Education: I agree and hereby consent to Dr. Buchanan performing dental work for and upon me as part of a "live patient" demonstration during a continuing dental education training course. I understand Dr. Buchanan will be the sole clinician performing the demonstration, and that course participants will be observing the procedure in its entirety. I further state that the nature and extent of the techniques, procedures, and treatment I will be receiving have been explained to me. I have been informed about the potential risks of using the techniques that will be applied as part of the demonstration.

I have been informed of alternative procedures that are available to me, and my options with respect to each such available alternative procedure. I am aware that one such option that is available to me is that I receive no treatment at all. Having considered the options and alternative procedures available to me, I have agreed to the specific procedure to be completed by Dr. Buchanan during this demonstration. I am aware that I have the absolute right to discontinue treatment at any time.

PLEASE SIGN IN THE SPACE BELOW UNLESS YOU HAVE QUESTIONS FOR THE DOCTOR.

If there is anything you do not understand about the endodontic procedure, or any statements in this form, or if you still have any questions after reading this form, please discuss them with the doctor before signing below. Thank you.

Signature _____ Date _____

L. Stephen Buchanan, DDS, FICD, FACD

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Diplomate of the American Board of Endodontics

Authorization for Disclosure of Patient Records

I hereby **authorize Dr. Stephen Buchanan DDS** to release my records to

_____ .

_____ _____

Print Patient Name Patient Signature

_____

Date