**West Valley Endodontics - Nampa**
1217 N Jacob Alcott Way
Nampa, Idaho 83687
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# West Valley Endodontics

**THE FOLLOWING CONFIDENTIAL INFORMATION IS FOR OUR RECORDS ONLY**
(Please Print)

Brent L. Chapman, DDS
Hilary I. Dunstan, DDS MS
Bruce E. Newcomb, DDS
Adam J. Shipp, DMD MS
Ryan C. Shipp, DMD MS

## *Patient Information*

Patient Name ______________________________ Age ____________
Date of Birth ______________________________ Home Phone ____________
Home Address ______________________________ Cell Phone ____________
City ______________________________ State ______ Zip Code ____________
Patient Employed By ______________________________
Business Address ______________________________ Business Phone ____________
City ______________________________ State ______ Zip Code ____________
Spouse Name (Parent if Minor) ______________________________ Business Phone ____________
Spouse Employer (Parent if Minor) ______________________________ City/St./Zip ____________
Emergency Contact ______________________________ Phone ____________
Referring Dentist ______________________________ General Dentist ____________

## *Insurance Information*

Primary **Dental** Insurance ______________________________ Ins. Phone # ____________
Subscriber Name ______________________________ Subscriber # ____________
Subscriber Date of Birth ______________________________ Subscriber's Employer ____________
Secondary **Dental** Insurance ______________________________ Ins. Phone # ____________
Subscriber Name ______________________________ Subscriber # ____________
Subscriber Date of Birth ______________________________ Subscriber's Employer ____________

Provided with your insurance information, we will gladly file your insurance claims. ***However, please keep in mind that benefit reimbursement is a contract between you*** and ***your insurance company.*** I authorize the release of my information required by my insurance company. I also authorize payment of benefits directly to the dentist.

Signature Date

## *PLEASE FILL OUT THE FOLLOWING IF YOU HAVE EXPERIENCED ANY PAIN FROM YOUR TEETH:*

Is the pain localized to a definite area of your mouth? . . . . . . . . . . ☐ Yes ☐ No
Is it a specific tooth? . . . . . . . . . . ☐ Yes ☐ No
Does any particular stimulus produce the pain? – Hot, cold, sweetness, pressure, chewing, lying down, etc.?
Please List: ______________________________
Is the pain described as being sharp, throbbing or a dull ache? ______________________________
Does the pain last for seconds, minutes, or is it continuous? ______________________________
Does the pain spread to other areas of your mouth or head? . . . . . . . . . . ☐ Yes ☐ No
Does the tooth in question feel misaligned or out of position? . . . . . . . . . . ☐ Yes ☐ No
When did the toothache start? ______________________________
Is there swelling? . . . . . . . . ☐ Yes ☐ No When did the swelling start? ____________
Did you ever suffer a blow to this area of your mouth? . . . . ☐ Yes ☐ No When? ____________

**PLEASE COMPLETE MEDICAL HISTORY ON REVERSE SIDE**

### *Medical History*

Medical Physician's Name ______________________

Address ______________________ Phone ______________________

Are you in good health? ☐ Yes ☐ No

Has there been any change in your health in the last year? ☐ Yes ☐ No

Are you presently under the care of a physician? ☐ Yes ☐ No

When was your last medical examination? ______________________

Have you ever been seriously ill? ☐ Yes ☐ No

Have you ever been hospitalized? ☐ Yes ☐ No

Check any of the following that you have or have had:

| | | | |
|---|---|---|---|
| ☐ Heart Condition | ☐ Thyroid/Hormonal | ☐ Migraine/Headaches | ☐ Pacemaker |
| ☐ H/L Blood Pressure | ☐ Hepatitis | ☐ Epilepsy/Fainting | ☐ MVP |
| ☐ Respiratory/Asthma | ☐ Sinusitis | ☐ Glaucoma/Visual | ☐ Heart Murmur |
| ☐ Rheumatic Fever | ☐ Tuberculosis | ☐ Mental/Neural | ☐ HIV/AIDS |
| ☐ Jaundice/Liver | ☐ Radiation/Chem | ☐ Tumor/Neoplasms | ☐ Phen/Phen |
| ☐ Immunocompromised | ☐ Cancer | ☐ Alcoholism/Addiction | ☐ Other ______ |
| ☐ Anemia/Bleeding | ☐ Rheumatoid Arthritis | ☐ Infectious Diseases | ______ |
| ☐ Diabetes/Kidney | ☐ Osteoporosis | ☐ Venereal Disease | ______ |
| ☐ Herpes | ☐ Ulcers/Digestive | ☐ Joint Replacement | ______ |

Please list any **ALLERGIES** to medications or foods:

______________________

Are you taking any medicines, supplements or herbals? ☐ Yes ☐ No

If yes, please list: ______________________

Do you stop bleeding normally after a cut or injury? ☐ Yes ☐ No

Do you heal normally? ☐ Yes ☐ No

If female, are you pregnant? ☐ Yes ☐ No

**The Purpose** of endodontic treatment or root canal treatment is an attempt to save a tooth rather than removing it. Although treatment has a high degree of success, it can't be guaranteed. Occasionally, when a tooth has had a root canal treatment, it may require re-treatment, surgery, or even extraction.

Treatment is usually a non-surgical procedure, but in some cases, a surgical approach is necessary. Before any treatment is begun the reason(s) will be explained, including alternative modes of therapy. Occasionally, pre-medication may be indicated. This will be discussed in advance.

**PLEASE NOTE: The fee will not include a permanent filling or crown on the tooth. You must return to your general dentist to have your treatment completed.**

Consent is hereby given to West Valley Endodontics and to the treating Endodontist to administer treatment that is deemed necessary. I agree to pay all fees incurred for exams and/or treatment in this office. 1.5% per month will be assessed on all accounts that are over 60 days ($1.00 minimum)

**Signature** ______________________ **Date** ______________________

### *Notice of Privacy Practices*

I acknowledge that I have been given or offered a copy of this office's Privacy Practices information.

**Signature** ______________________ **Date** ______________________

# West Valley
## - ENDODONTICS -

### ENDODONTIC INFORMED CONSENT

We would like to take this opportunity to inform our patients of the procedures that are involved in endodontic therapy and have their consent before starting the treatment. Endodontic (Root Canal) therapy is performed in order to save a tooth that otherwise might need to be removed. This is accomplished by conservative root canal therapy, or when needed, endodontic surgery. The following discusses the possible risks that may occur from endodontic treatment and other treatment choices.

**Risks:** The risks include the possibility of instruments broken within the root canal, perforations of the crown or root of the tooth, damage to crowns or bridges or existing fillings when gaining access to the canals. During the treatment, complications may occur making the treatment impossible. These complications may include blocked canals, natural calcifications, broken instruments, curved roots, periodontal disease or fractures in teeth. Temporary or permanent numbness of teeth, lip, gum, chin and cheek may occur as a result of the administration of the anesthetic solution.

**Medications:** Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedative or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effects.

**Other treatment choices:** These include no treatment (waiting for more definite development of symptoms) or tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth and infection to other areas.

**Consent:** I the undersigned, being the patient (or parent or guardian of minor child), consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. I also understand that upon completion of root canal therapy in this office, I shall return to my general dentist for a permanent restoration of the tooth involved, such as a filling, onlay or a crown.

I understand that root canal therapy is an attempt to save a tooth, which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth that has already had root canal therapy may require retreatment, surgery, or even extraction.

______________________________________________________________________

**Patient Signature** **Date**

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