



Suite 203,
933 Mamaroneck Avenue,
Mamaroneck, NY 10543
T 914.698.6811 F 914.698.4134
www.westchesterendodonticcare.com

Salina W. Wu, DDS., PLLC.
Martin H. Diamond, DMD
Practice Limited to Endodontics

ABOUT YOU

Mr. Mrs. Ms. Dr. Date: _____

Name: _____
(Last) (First) (MI)

I prefer to be called: _____ Male Female

Birthdate: ____/____/____ Age: _____

Social Security No. _____

Home Address: _____

City State Zip

Marital Status: Single Married Divorced Widowed

Home Phone: (____) _____ Cell: (____) _____

Work: (____) _____ Ext.: _____

Email address: _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous/ Present Dentist: _____

Emergency Contact: _____

Emergency Contact Phone No.: (____) _____

PRIMARY INSURANCE

Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: (____) _____

Group # (Plan, Local or Policy #): _____

Insured Name: _____ Relation: _____

Insured Birthdate: ____/____/____ SS#: _____

Insured Employer: _____

Employer's Address: _____

SECONDARY INSURANCE

Dental Coverage? Yes No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: (____) _____

Group # (Plan, Local or Policy #): _____

Insured Name: _____ Relation: _____

Insured Birthdate: ____/____/____ SS#: _____

Insured Employer: _____

Employer's Address: _____

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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.

Signature _____

Date _____

CONSENT FOR LOCAL ANESTHETIC INJECTIONS

I, (print name) _____, hereby authorize

Dentist/Hygienist/Other (print name) _____ to perform a local

anesthetic injection(s).

I understand, and it has been explained to me, that there are some risks in the administration of local anesthetics. Most risks are related to the position of the nerves under the tissue at the site of the injection which can not be determined prior to the administration of the anesthetic agent. Although the risks seldom occur they might include loss of, or disturbed sensation of the tongue and lip on the side of the injection. If this occurs it is often temporary, and normal sensation usually returns in several days. However, in very rare cases the loss of sensation may extend for a longer period and may become permanent. In addition, injecting a foreign substance into the body such as an anesthetic agent, may result in an allergic reaction. Allergic reactions to these agents are rare, but may take place.

I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions following the injection(s), I agree to report them to the office as soon as possible.

I have been told that the success of my dental treatment depends upon my cooperation in keeping scheduled appointments, following home care instruction, including oral hygiene and dietary instructions, taking prescribed medication and reporting to the office any change in my health status.

I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

I have discussed all of the above with the doctor, and have had all of my questions answered.

Patient's Signature

If a Minor, Signature of Parent Or Guardian

Witness Signature

Dentist/Hygienist/Other Signature

Date



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Reasons for Treatment

Endodontic (root canal) therapy is accomplished in an effort to save a tooth which otherwise would require extraction. Treatment is done by standard root canal therapy, or when necessary, endodontic surgery.

Other Treatment Choices

These include no treatment at all, waiting for more definitive symptoms to develop, and tooth extraction. The risks involved in these choices may include pain, infection, swelling loss of teeth, and spread of infection to other areas.

Risks Specific to Endodontic Therapy

Those risks include the possibility of instruments broken within the root canals, perforation/s (extra openings) of the crown or root of the tooth; damage to bridges, existing fillings, crowns, fracture of porcelain, loss of tooth structure in obtaining access to the canals, and cracked teeth. During treatment complications may be discovered which make treatment impossible, or which may require endodontic surgery. These complications may include: blocked canals due to previous fillings or prior root canal treatment, natural calcification/s, broken instruments, curved roots, periodontal disease (gum disease), splits or fractures of the teeth and reabsorption.

Other Risks of Treatment

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: swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, which is transient but on rare occasions may be permanent, reaction to injections, changes in occlusion (the bite), jaw muscle cramps and spasms, Temporomandibular joint (TMJ) difficulty or injury to the jaw and supporting structures. Preexisting problems with (TMJ) jaw joint may be aggravated or worsened as a result of treatment, loosening of teeth, referred pain to the ear, neck and head, nausea, vomiting, allergic reactions, delayed healing, sinus perforations and treatment failure.

Medications

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

Consent

I, the undersigned, being the patient (parent or guardian of minor patient) consent to the performing of procedures deemed 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 referring and/or regular dentist for a permanent restoration of the tooth involved. This restoration may be a crown (cap), jacket, only or silver filling. I understand that root canal treatment 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 which has had root canal therapy may require retreatment, surgery or even extraction.

Name of Patient _____

Patient/Guardiant Signature _____

Witnessed By _____ Date _____