BOHNING ENDODONTICS
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Patient Introduction

PLEASE PRINT

PATIENT

MR.
MS.
MRS.
MISS _____
PATIENT LAST NAME FIRST NAME MIDDLE

ADDRESS STREET APT. NO. CITY STATE ZIP

SOCIAL SECURITY #	DATE OF BIRTH	DRIVER'S LICENSE #	STATE	HOME PHONE

EMPLOYED BY	SPOUSE'S NAME / EMPLOYED BY
EMPLOYER'S ADDRESS	EMPLOYER'S ADDRESS
OCCUPATION / BUS. PHONE	OCCUPATION / BUS. PHONE

HAVE YOU BEEN A PREVIOUS PATIENT OF ANY OF OUR DOCTORS? ☐ YES ☐ NO

NAME OF FRIEND OR NEIGHBOR TO CONTACT IN CASE OF EMERGENCY _____ PHONE _____

WHOM MAY I THANK FOR REFERRING YOU?

NAME

ADDRESS CITY STATE ZIP

WHO IS YOUR FAMILY DENTIST?

NAME

ADDRESS CITY STATE ZIP

RESPONSIBLE PARTY

IF YOU HAVE DENTAL INSURANCE

PRIMARY INSURANCE CARRIER NAME OF INSURED SOCIAL SECURITY #

SECONDARY INSURANCE CARRIER NAME OF INSURED SOCIAL SECURITY #

I agree to pay the insurance deposit today. I understand I am responsible for any portion not paid by my insurance company and will pay that amount within 15 days after my insurance company remits their portion. I agree to pay any fees associated with the collection of this amount should it fall past due. I certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am ultimately responsible for payment of services.

X _____
Signature

IF YOU DO NOT HAVE DENTAL INSURANCE

☐ I will pay all fees in full today. ☐ I will make a partial payment today. I will pay the balance as agreed upon.

I certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I agree to pay any fees associated with the collection of this amount should it fall past due.

X _____
Signature

I understand Root Canal treatment is a procedure to retain a tooth which may otherwise require extraction. Although Root Canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Occasionally, a tooth which has had Root Canal therapy may require retreatment, surgery, loss of dental prosthesis or extraction.

I also understand that only the Root Canal treatment is to be performed at this office. The permanent (outside) restoration (filling, onlay, crown, bridge, etc.) will be done by my regular dentist.

Louisiana Law now requires informed consent understood and signed by you before dental treatment. You must be informed of all risks of the procedure to be done and medications to be given, **no matter how rare.**

Some risks associated with the procedures include fracture or loss of teeth, continued pain, infection, swelling, bleeding, trismus (restricted jaw opening), discoloration, the need for additional treatment or surgery, difficulty with diagnosis especially if more than one tooth needs treatment at the same time, inability to diagnose all crown root fractures, paresthesia (numbness, tingling) separated instruments, overextension of filling materials, inability to negotiate all canals, damage to your present restoration, including fracture to porcelain crowns, and swallowing or aspiration of foreign objects.

Some risks associated with the medications include: allergic reactions (rash, itching, swelling, death), gastrointestinal problems (nausea, vomiting, diarrhea, colitis), cardiovascular problems (shortness of breath, respiratory depression) and neurologic problems (drowsiness, coma, paralysis).

Louisiana law also requires us to mention the risks of brain damage, or disfiguring scars associated with such procedures. Complications may require hospitalization and may even result in death.

I have read the preceding risks that may occur in connection with this procedure. I believe I have been given and understand sufficient information to give my consent to the above treatment, and for Dr. _____ to administer anesthetics and medications he/she deems necessary for the care of the patient named above.

I authorize release of any information relating to my dental health care.

PATIENT/LEGALLY RESPONSIBLE PERSON: X _____

DATE: _____ WITNESS: _____