Welcome to the Office of

Dr. Liwen Tao, DDS, MS, PA

And Associates

Your Personalized Root Canal Specialists

For Office Use Only:

Health History Updated

Date_____

Patient Information (Please print legibly)

Name_____ Married (M)/Single (S) _____ Date_____

Address_____ Apt#_____

City_____State_____Country_____Zip_____

Home # (_____)_____ Work # (_____)_____ Cell # (_____)_____

SSN_____ Date of Birth _____Age_____

Driver License #_____

Email Address_____

Employer_____Occupation_____

Who Referred You to Us? _____ Your General Dentist_____

Emergency Contact Information

Name_____ Relationship_____ Phone # (_____)_____

Medical History

1. Check any of the following which you have had or suspect you have:

_____Heart Trouble
_____Heart Murmur
_____Mitral Valve Prolapse
_____Rheumatic Fever
_____Artificial Valve
_____Pace Maker
_____High/Low Blood Pressure
_____Artificial Bones/Joints
_____Angina
_____HIV/AIDS
_____Drug/Alcohol Abuse
_____Kidney Trouble
_____Glaucoma
_____Cancer/Chemotherapy/Radiation
_____Severe Headache
_____Bleeding Disorder
_____Thyroid Disease
_____Diabetes
_____Asthma
_____Tuberculosis
_____Ulcers/Colitis
_____Hepatitis A B
_____Epilepsy/Seizures/Fainting
_____Psychiatric Problems
_____Liver Disease
_____Other: _____

2. Are you allergic to or suffer ill effects from any of the following?

_____Penicillin _____Codeine _____Dental Anesthetics _____Aspirin _____Latex

Other_____

3. Can you use Vasoconstrictors/ Epinephrine? _____

4 Are you taking any of the following?

_____Steroids _____Blood Thinners _____Tranquilizers _____Daily Aspirin

5. Which medications are you currently on? _____

6. Are you under a physician's care? _____No _____Yes

7. Women only: Are you pregnant? _____No _____Yes. If yes, week #_____Nursing_____?

OUR PAYMENT/PRIVACY POLICY

Our payment policy is **payment as services are rendered.**

Payment Method: Check ___Cash _____Debit Card ___Credit Card

We will gladly accept your dental insurance as a courtesy and will complete the necessary forms with your copayment and deduction. **Chronic No SHOWS/CANCELLATIONS WILL RESULT IN A CHARGE OF $50.00. Please call our office 24 hours in advance if you need to cancel.**

ENDODONTIC INFORMED CONSENT

Endodontic treatment has a 95% success rate. As in any medical or dental treatment however, this treatment has no guarantee of success for any length of time. The possible complications include but are not limited to:

1. Postoperative discomfort and swelling lasting different lengths of time for which medication will be prescribed if deemed necessary by the doctor.

2. Continued infection requiring re-treatment, endodontic surgery or extraction of the tooth.

3. Calcified canals or canals blocked by separated instruments, over-extended material, requiring endodontic surgery or extraction.

4. Trismus or tingling on the lip, tongue, or chin postoperatively which is usually temporary.

5. Perforation of the root canal with instruments, which may require additional surgical corrective treatment or extraction.

6. Fracture of the crown of the tooth during or after treatment. If you already have a crown, there is a chance that it will need to be replaced due to decay or insufficient structural support. Porcelain crowns are subject to breakage.

7. If the endodontic surgery is needed, temporary bleeding, perforation of the sinus and damage of the nerve may occur.

I understand and authorize the performance of the necessary dental services that I may need. I fully understand the informed consent. It is my responsibility to inform this office of any change of my medical status.

****I understand that I will return to my regular dentist after the completion of root canal therapy for permanent restoration in order to save my tooth. This office does not include this service.**

****I realize that I am financially responsible for charges related to the treatment**. This office respectfully reserves the right to reschedule an appointment for anyone who cannot meet their fee for services.

** **I consent to the use or disclosure of my protected health information by Liwen Tao, D.D.S., M.S. P.A, for the purpose of providing treatment to me, obtaining payment, or to conduct health care operations of Dr. Liwen Tao, D.D.S, M.S. P.A.. I understand I have the right to review Dr. Liwen Tao's Privacy Practices and if I would like a copy one will be provided. Any restrictions I may have of the use of my protected health information by Dr. Liwen Tao's office will be communicated by me to the office in writing.**

Signature_____Date_____