PATIENT INFORMATION AND CONSENT FORM

I understand I will be seeing an Associate Endodontist of F. Mike Bardi, D.D.S., APC. My doctor is an independent contractor and is not an employee of F. Mike Bardi, D.D.S., APC. I allow the associate endodontist to evaluate my tooth/teeth for endodontic treatment.

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<tr>
<th>Patient/Parent Signature</th>
<th>Print Name</th>
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TOOTH IN QUESTION: # _____ / # _____ / # _____ / # _____ / # _____ / # _____ (OFFICE USE ONLY)

We believe that a patient must be well informed about any treatment and their consent must be given before starting the treatment. The purpose of this form is to inform you of the risks and complications that can occur, however infrequent, during a root canal treatment.

Endodontic treatment (root canal) is performed in an attempt to save a tooth which otherwise might require extraction. Although Endodontic treatment has a high degree of success, no guarantee can be given. Root canal treatment generally takes one to two visits and requires the use of local anesthetic and x-rays.

PLEASE INITIAL

_____ I understand that 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 may include pain, swelling, infection, loss of tooth or teeth, and infection to other areas.

_____ I understand that in some cases, the tooth may require re-treatment of previous root canal therapy. Some complications may be encountered during this procedure due to previous treatment such as blockage, perforation, or broken instrument that may require endodontic surgery or even extraction in order to resolve.

_____ I understand that the crown of the tooth may be cracked. Some cracks that extend from the crown down into the roots are invisible and undetectable. If a fracture occurs before or after the root canal treatment, the tooth may require extraction.

_____ I understand that Endodontic surgery may be suggested as the best option. Surgeries that might be performed include: dividing a tooth in half, repairing an injured root, or even removing one or more roots. Intentional re-plantation may be performed where the tooth will be extracted, treated, and then replaced in the socket.

_____ I understand that there may be complications resulting from the use of dental instruments, drugs, medicines, analgesics, anesthetics, and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensation on the lips, tongue, chin, gums, cheek and teeth, discoloration of tooth, discoloration of the face, antibiotic that may inhibit the effectiveness of birth control pills, thrombophlebitis (inflammation of the vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of the teeth or restorations in the teeth, injury in other tissues, referred pain to the ear, neck and head, nausea, vomiting, allergic reactions, itching, bruises, delayed healing, sinus complications and further surgery.

_____ I understand that specific risks to endodontic therapy can include instruments broken within the root canal(s), perforations (extra opening) of the crown or root of the tooth, damage to bridges, existing fillings, crowns or porcelain veneers, loss of tooth structure in gaining access to canals, and fracture of tooth structure. If existing restoration is either damaged or destabilized, a new restoration may be indicated.

_____ I understand that during treatment, complications may be discovered which makes the treatment impossible, or may require Endodontic surgery. These complications may include: blocked or obstructed canals resulting from fillings, prior treatment, natural calcification, broken instruments, curved roots, perforations, periodontal disease (gum disease-Pyorrhea) and fractures of the teeth.

_____ I understand that after the completion of the Root Canal treatment, I will need to return to my regular dentist for the permanent restoration.

_____ I understand that a perfect result is not guaranteed or warranted and cannot be guaranteed or warranted on roots canals, re-treatments, and surgical procedures.

During the course of the treatment, every effort will be made to achieve successful results and to keep you as comfortable as possible.

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<tr>
<th>Patient/ Parent Signature</th>
<th>Doctors Initials</th>
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BROKEN APPOINTMENT FEE POLICY

Appointment for specialty care is in demand. We require a 24-hour notice in advance if you are unable to keep your scheduled appointment. If you fail to provide a 24-hour cancelation notice, you will be charged for the missed appointment. Those fees may vary from $100 to $200 per appointment.

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**HEALTH HISTORY**

Please answer each question by checking the appropriate box or circling YES or NO:

1. Are you in good health?................................................................. Yes No
2. Date of last physical examination: __________________________
3. Are you now under the care of a physician? ........................................... Yes No
   If yes, what is the condition being treated?
   Doctor’s name: __________________________________________
   Telephone #: __________________________________________
4. Have you ever had any serious illness or operation or been hospitalized? ........................................................................... Yes No
5. Are you taking any medication? ......................................................... Yes No
   If yes, what? ________________________________________________ What dosage?
6. Are you using any recreational drugs (e.g.marijuana, cocaine) or controlled substances? ......................................................... Yes No
   If yes, what?
7. Have you ever been pre-medicated with antibiotics for your dental treatment? ................................................................. Yes No
8. Are you sensitive or allergic to any drugs or materials? __ Aspirin __ Penicillin __ Tetracycline __ Erythromycin
   __ Codeine __ Latex __ Other If Other, please list: ____________________________
9. Do you have or have you had any of the following: Please check “Y” for Yes or “N” for No – answer all conditions:
   Y / N Aids
   Y / N Allergies or Hives
   Y / N Anemia
   Y / N Angina Pector
   Y / N Arthritis
   Y / N Artificial Heart Value
   Y / N Asthma
   Y / N Blood Disease
   Y / N Blood Transfusion
   Y / N Bruise Easily
   Y / N Chemotherapy
   Y / N Cold Sores
   Y / N Congenital Heart Lesions
   Y / N Diabetes
   Y / N Drug Addiction
   Y / N Emphysema
   Y / N Epilepsy or Seizures
   Y / N Excessive Bleeding
   Y / N Fainting Spills/ Seizures
   Y / N Hay Fever
   Y / N Head Injuries
   Y / N Heart Ailments or Attack
   Y / N Heart Failure
   Y / N Heart Murmur
   Y / N Heart Murmur
   Y / N Hemophilia
   Y / N Hepatitis of Jaundice
   Y / N Herpes
   Y / N High Blood Pressure
   Y / N HIV Positive
   Y / N Joint Replacement
   Y / N Kidney Disease
   Y / N Liver Disease
   Y / N Malaria Prolapse
   Y / N Mental Disorder
   Y / N Mitral Valve Prolapse
   Y / N Nervous Disorders
   Y / N Pain in Jaw Joints
   Y / N Psychiatric Treatment
   Y / N Radiation Treatment
   Y / N Rheumatic Fever
   Y / N Rheumatism
   Y / N Sickle Cell Disease
   Y / N Skin Trouble
   Y / N Stomach Ulcers
   Y / N Tonsillitis
   Y / N Tuberculosis
   Y / N Tumors or Growths
   Y / N Venereal Disease
   Y / N Viral Disease
   Y / N Vomiting
   Y / N Respiratory Disease
   Y / N Thyroid Disease
   Y / N TMJ
   Y / N Uterine Fibroids
   Y / N Venereal Disease
   Y / N Venereal Disease
   Y / N Venereal Disease

10. Do you wear a cardiac pacemaker, or have you had heart surgery? If yes, please explain: ____________________________ Yes No
11. Do you smoke, chew, use snuff or any other forms of tabacco? __ Cigarettes __ Cigars __ Chew __ Snuff __ Other
   If yes, how much?
12. Do you consume alcoholic beverages? If yes, how much? ____________________________ Yes No
13. Have you ever taken the drug “Fen-Phen” or “Redux”? ......................................................... Yes No
14. Are you pregnant? If yes, how many months? ____________________________ N/A Yes No
15. Do you have any problems associated with your menstrual period? ................................................................. Yes No
16. Do you take birth control pills? ................................................................. Yes No
17. Have you ever had a change in any medical condition or had surgery? ................................................................. Yes No
   If yes, please explain: ____________________________________________
18. Are you taking any medication? ......................................................... Yes No

**I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE**

___ Signature: __________________________

(If patient is a minor, include printed name and signature of parent or legal guardian)

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**UPDATE- Since your last visit:**

1. Have you seen a medical doctor? ............... Yes No
2. Have you had a change in any medication? ...... Yes No
3. Have you had a change in any medical condition or had surgery? ................................................................. Yes No

If yes, please explain: ____________________________________________

Date: ________________ Signature: __________________________

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**DO NOT WRITE IN THIS SPACE**

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<thead>
<tr>
<th>DATE</th>
<th>B.P.</th>
<th>PULSE</th>
<th>REVIEWED BY</th>
<th>DENTIST’S COMMENTS</th>
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PLEASE PRINT (BLUE OR BLACK INK ONLY)

Patient

_____________________________  __________________________  __________________________  __________________________
Last Name  First Name  Middle Initial  Preferred Name

Home/Cell Phone__________________________  Social Security # __________________________

Mailing Address

____________________________________________________________  ______________________________________________________________
Street  City  State  Zip Code

Sex M F Age________ Birthdate / / Single Married Widowed Separated Divorced

Employed By (if minor, list school) __________________________  Occupation __________________________

Business Address__________________________  Business Ph# __________________________

Insured’s Name__________________________  SS# __________________________  Birthdate / /

Insured Employed By __________________________  Occupation __________________________  Work Ph# __________________________

Primary Dental Insurance Co. __________________________  Group# __________________________

Secondary Insured’s Name __________________________  SS# __________________________  Birthdate / /

Secondary Dental Insurance Co. __________________________  Employer __________________________  Group# __________________________

Emergency Contact__________________________  Phone Number __________________________

Whom may we thank for referring you__________________________  Dentist Name__________________________

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with __________________________ and assign to RootVision Endo __________________________

Name of Insurance Company/Companies

all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure the payment for benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

___________________________  _________________
Date  Signature

MINOR CHILD CONSENT

I, being the parent or guardian of __________________________ do hereby request and authorize the dental __________________________

Name of Minor/Child

staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

___________________________  _________________
Date  Signature

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of consultation/treatment unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for consultation/treatment of a minor/child. I accept full __________________________

financial responsibility for all charges not covered by insurance. I am aware that I am responsible for any cost(s) incurred in collection of a delinquent account.

___________________________  _________________
Date  Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below you are acknowledging receipt and understand all written information regarding our offices’ privacy practices.

___________________________  _________________
Date  Signature

RVE UPDATED 03-21-2015