specialist member

JOHN W. DISTEL, D.M.D., M.S.

SPECIALIST IN ENDODONTICS

JOHN W. DISTEL, D.M.D., M.S., LTD.

900 W. ROUTE 22, SUITE 160 LAKE ZURICH, IL 60047

PLEASE FILL OUT BOTH SIDES COMPLETELY

DATE	CELL PHONE		REFERRED BY:	REASON FOR VISIT	
NAME			HISTORY OF CLENCH/GRIND TEETH YES NO	DO YOU WEAR A NIGHT GUARD	
SPOUSE			DO YOU HAVE A TOOTHACHE? HOW LONG?		
ADDRESS			IF YES, WHAT PROVOKES YOUR TOOTHACHE? CIRCLE ALL THAT APPLY COLD HOT BITING OTHER		
CITY	STATE	ZIP	DESCRIBE THE CHARACTERISTICS OF YOUR PAIN. CIRCLE ALL THAT APPLY SHARP DULL CONTINUOUS INTERMITTENT THROBBING LOCALIZED DIFFUSE		
HOME PHONE	WORK PHONE				
BIRTHDATE	AGE	MALE/FEMALE	DO YOU HAVE SWELLING? HOW LONG AGO?		
EMAIL			HAS THE TOOTH HAD ROOT CANAL TREATMENT BEFORE? WHEN?		
SOCIAL SECURITY #			IS THERE ANY HISTORY OF TRAUMA TO THE TOOTH?		

In the following questions, check yes or no, whichever applies. Your answers are for our records only and will be considered confidential

	YES	NO		YES	NO
DO YOU USE TOBACCO:	____	____	**ALCOHOL/DRUG ADDICTIONS**	____	____
SMOKING ____ SNUFF ____ CHEW ____			**ULCERS OR STOMACH PROBLEMS**	____	____
DO YOU HAVE OR HAVE YOU EVER HAD:			**DENTAL ANXIETY**	____	____
MITRAL VALVE PROLAPSE	____	____	**TUBERCULOSIS**	____	____
PROS. DEVICES/JOINT REPLACEMENT	____	____	**HERPES**	____	____
DO YOU PREMEDICATE	____	____	**CANCER**	____	____
ABNORMAL HEART CONDITION	____	____	**CURRENT CANCER DRUGS/TREATMENT**	____	____
IF YES PLEASE EXPLAIN _____			**AIDS OR HIV**	____	____
ABNORMAL BLEEDING FROM A CUT	____	____	**THYROID/HORMONAL**	____	____
OSTEOPOROSIS MEDICATIONS	____	____	**ARE YOU PREGNANT**	____	____
IF YES PLEASE LIST: _____			**ALLERGY TO MEDICATION**	____	____
HIGH BLOOD PRESSURE	____	____	**IF YES, WHAT?** _____		
ANEMIA	____	____	**ALLERGY TO CLOVE/ CLOVE OIL**	____	____
LIVER PROBLEMS OR HEPATITIS	____	____	**ALLERGY TO LOCAL ANESTHETIC**	____	____
KIDNEY PROBLEMS	____	____	**ALLERGY TO LATEX**	____	____
DIABETES	____	____	**OTHER** _____		
ASTHMA	____	____	_____		

ANY OTHER MEDICAL CONDITION WE SHOULD BE AWARE OF: _____

ARE YOU UNDER THE CARE OF A PHYSICIAN NOW? _____ NAME OF PHYSICIAN _____ PHONE _____

LIST ALL PRESCRIPTIONS, HERBAL AND OVER-THE-COUNTER MEDICATIONS YOU ARE PRESENTLY TAKING

_____

_____

_____

ANTIBIOTICS ARE OFTEN PRESCRIBED IN THE COURSE OF DENTAL TREATMENT. THEY CAN INTERFERE WITH THE ABSORPTION OF BIRTH CONTROL PILLS, THUS MAKING THEM INEFFECTIVE. WHILE TAKING ANTIBIOTICS, ALTERNATIVE METHODS OF CONTRACEPTION ARE RECOMMENDED.

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME	PHONE #		
ADDRESS	CITY, STATE & ZIP		
EMPLOYER	PHONE #		
ADDRESS	CITY, STATE & ZIP		
YOUR SPOUSE'S NAME			
SPOUSE EMPLOYER	PHONE #		
ADDRESS	CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCIES			
PHONE NUMBER			

DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY	
GRP #	EMPLOYEE SS# OR MEMBER ID#
EMPLOYEE	
DATE OF BIRTH	

SECONDARY CARRIER

INSURANCE COMPANY	
GRP #	EMPLOYEE SS# OR MEMBER ID#
EMPLOYEE	
DATE OF BIRTH	

CONSENT FOR TREATMENT

I understand the following:

1. Endodontics as with any branch of medicine or dentistry, is not an exact science. Therefore, no guarantee of treatment success can be given or implied. As a rule, 90%-97% of routine non-surgical cases, and 75% of surgical cases are successful.
2. Cases started in other offices or re-treatment cases may have a different outcome than expected under optimal conditions.
3. Proper post-treatment restoration is a necessity. I must contact my referring dentist, after completion of the endodontic therapy to arrange for the final restoration within thirty days.
4. It may be necessary to alter the tooth structure or remove the restoration of the tooth being treated, or go through existing crowns or bridgework.
5. Ceramic/glass restorations have a higher incidence of cracking and may need to be replaced by your dentist following endodontic treatment.
6. Possible complications of treatment include:
    a. Procedural difficulties in the course of treatment. (separated instrument, perforation, overfilling, etc.)
    b. Fracture of the crown or root.
    c. Swelling, pain or discoloration of the soft or hard adjacent tissues.
    d. Persistent numbness or sinusitis following endodontic surgical treatment.
    e. Additional unknown or unspecified problems, the explanation for and the responsibility of which cannot be given or assumed.
    f. Post-surgical infection.
7. Treatment will be performed in accordance with accepted methods of clinical practice. Included in the therapy will be the taking of a minimal number of x-rays as dictated by the course of treatment.

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC AND THE ADA.

Patient Signature _____ Date _____

*** Please note: 24 hours notice is required for non-surgical cancellations and 48 hours for surgery cancellations. Failure, by the patient, to give proper notice may result in a fee being charged to you.**