I AGREE TO PAY ANY AND ALL BALANCE AFTER PAYMENT HAS BEEN RECEIVED FROM MY INSURANCE COMPANY. PAYMENT WILL BE IN A REASONABLE AMOUNT OF TIME AND NOT TO EXCEED THIRTY (30) DAYS. IF THERE IS NO INSURANCE COVERAGE, I AGREE TO PAY ANY AND ALL BALANCES AT THE TIME OF SERVICE

Date_______________ ____
Signature of patient or legal guardian

Payment will be by (Please check)

_______ cash or check ________ Visa _______Mastercard _______Discover _______Amex

IF INS. APPLIES

We will be happy to file your dental insurance **as a courtesy** to you. We require your correct dental insurance information at the time of your appointment as well as your required individual Co-payment. You will be asked to sign the following authorization and any necessary dental insurance forms. Accounts past 90 days will have a 1.5% monthly finance charge applied to the unpaid balance in addition to any collection fees assessed to the account.

I hereby authorize release of all information relating to this claim and further authorize payment be made directly to Martin E. Kersh, D.M.D., P.C. of the insurance benefits, otherwise payable to me. I understand I am responsible for all charges not covered by this authorization.

Date_______________ ____
Signature of patient or legal guardian

WHEN ENDODONTIC TREATMENT IS COMPLETED, YOUR TOOTH WILL REQUIRE A PERMANENT RESTORATION. **OUR FEE DOES NOT INCLUDE THIS SERVICE.** YOUR GENERAL DENTIST WILL RENDER THIS SERVICE WHICH IS MANDATORY FOR THE PRESERVATION OF YOUR TOOTH.

Date_______________ ____
Signature of patient or legal guardian

CONSENT TO ENDODONTIC THERAPY

Please review the following consent. You will be required to sign it prior to the initiation of treatment; however, it does not commit you to treatment

This is my consent to the endodontic procedures indicated and any other procedures deemed necessary or advisable as a corollary to the planned endodontic therapy performed by the endodontist, Martin E. Kersh and any assistants with whom he works. I agree to the use of local anesthesia, depending upon the judgement of the endodontist. I understand the endodontist will consult with me prior to administering any sedation, and/or nitrous oxide analgesia. **Complications of root canal therapy and anesthesia may include swelling, pain, trismus (restricted jaw openings), infection, bleeding, sinus involvement, and numbness or tingling of the lip, gum or tongue, which rarely is protracted and even more rarely is permanent. I understand that it is my responsibility to report any symptoms to the endodontist immediately.**

I understand that the root canal therapy is a procedure to retain a tooth which may otherwise require extraction and that as a specialty practice, the office performs only endodontic therapy and associated surgery. Although root canal therapy has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery, or even extraction. Following treatment, the tooth may be brittle and subject to fracture. A restoration (filling), crown, and/or post and core will be necessary to restore the tooth to function; this will be performed by your general dentist. During treatment there is the possibility of instrument separation within the root canals, perforations (extra openings), damage to bridges, existing fillings, crowns or procelain veneers, missed canals, loss of tooth structure in gaining access to canals, and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when a tooth may not be amendable to endodontic treatment at all. Other treatment choices include: no treatment, waiting for more definitive symptoms to develop, or tooth extraction Risks involved in those choices might include but are not limited to pain, infection, swelling, loss of teeth and infection to other areas.

At times, medication will be prescribed by the endodontist. I understand that medications for discomfort and sedation may cause drowsiness which can be increased by the use of alcohol or other drugs. I am advised against the use of alcohol or operating any vehicle or hazardous devices while taking such medications. I further understand that certain medications may cause hives and intestinal problems and if any of these reactions occur, I am to call the endodontist immediately. I understand that it is my responsibility to report any changes in my medical history to the endodontist.

I fully understand the above statements in this consent.

Date:________________ ____
Signature of Patient or legal guardian

Martin E. Kersh, D.M.D., P.C.

Specialist in Endodontics

We welcome you to our office. Please **PRINT** information. Thank You.

Patient Name ____
First Mid. Init. Last

Home Address ____

City_______________________ State__________ Zip____________

Birthdate ________________ Social Security # ________________

Your Home Phone #________________ Work Phone #________________

Your E-Mail Address____________________ Cell #________________

Your Employer____

Name of General Dentist____________________________________

Who should we thank for this referral?______________________

If Ins. Applies: Spouse or Guardian_________________________

Spouse / Guardian Social Security #________________ Birthdate____________

Spouse / Guardian Employer ________________ Phone #____________

If Patient is a Minor: *(This portion to be completed by parent/guardian accompanying child)*

Name of financially responsible person:______________________

Relation:________________ SS#________________________

Birthdate________________ Work Phone: ________________

PATIENT MEDICAL HISTORY

		Yes	No
1.	Are you under medical treatment now?	❑	❑
	Name of Medical Physician________________ Phone:____________		
	Date of last Medical Exam?________________		
2.	Have you ever been hospitalized for any surgical operation or serious illness?	❑	❑
3.	Are you taking daily medication?	❑	❑
	If yes, please list:____________________________		
4.	Do you use tobacco?	❑	❑
5.	Do you drink alcohol?	❑	❑
6.	Do you use cocaine or other drugs?	❑	❑
7.	Do you grind your teeth?	❑	❑
8.	Are you taking a blood thinner? (ie Aspirin, Coumidin, Other)	❑	❑
	If Yes, Please List:____________________________		
9.	Are you currently taking diet medication?	❑	❑
	If Yes, Please List:____________________________		

10. Are you allergic to or have you had any reactions to the following?

Yes	No		Yes	No		Yes	No	
❑	❑	Local anesthetics (i.e. novocaine)	❑	❑	Barbiturates	❑	❑	Aspirin
❑	❑	Penicillin	❑	❑	Sedatives	❑	❑	Codeine
❑	❑	Sulfa Drugs	❑	❑	Iodine	❑	❑	Latex
❑	❑	Other Antibiotics*	❑	❑	Sulfites	❑	❑	Other*

*Please List: ________________________________

11. Do you have any medical conditions which require **PREMEDICATION** with antibiotics prior to dental work (i.e. MVP, Heart Murmur)? ❑ ❑

12. Are you currently taking or have you previously taken bisphosphonate medications, such as Actonel, Fosamax or Zometa within the past twelve years ? ❑ ❑

13. **WOMEN ONLY**

	Yes	No
a) Are you pregnant or think you may be pregnant?	❑	❑
b) Are you nursing?	❑	❑
c) Are you taking birth control pills?	❑	❑

14. Do you have or have you had any of the following?

YES	NO		YES	NO	
❑	❑	High Blood Pressure	❑	❑	Heart Disease
❑	❑	Chest Pains	❑	❑	Heart Attack
❑	❑	Cardiac Pacemaker	❑	❑	Easily Winded
❑	❑	Rheumatic Fever	❑	❑	Heart Murmur
❑	❑	Leukemia	❑	❑	Mitral Valve Prolapse
❑	❑	Stroke	❑	❑	Swollen Ankles
❑	❑	Angina	❑	❑	Frequently Tired
❑	❑	Fainting / Seizures	❑	❑	Bleeding Disorder
❑	❑	Tuberculosis	❑	❑	Asthma
❑	❑	Anemia	❑	❑	Radiation Therapy
❑	❑	Low Blood Pressure	❑	❑	Emphysema
❑	❑	Glaucoma	❑	❑	Epilepsy / Convulsions
❑	❑	Cancer	❑	❑	Recent Weight Loss
❑	❑	Hepatitis / Jaundice	❑	❑	Arthritis
❑	❑	Liver Disease	❑	❑	Diabetes
❑	❑	Joint Replacement	❑	❑	Heart Trouble
		or implant	❑	❑	Kidney Diseases
❑	❑	Prosthetic Heart Valve	❑	❑	Respiratory Problems
❑	❑	AIDS or HIV Infection	❑	❑	Thyroid Problem/Disease
❑	❑	Sexually Transmitted Diseases	❑	❑	Other________________

Medical Hx Reviewed:________________________ Date:____________

________________________ Date:____________