Commonwealth Endodontics
WE SAVE TEETH.

www.cwendo.com
Tel: 804-501-0501

PATIENT INFORMATION

Date: _____ Referred by: _____ General Dentist: _____ Tooth #: _____

Patient _____ _____ _____ _____
LAST FIRST Nickname/Pronouns MI

DOB _____ SSN _____ □ MALE □ FEMALE □ CHILD*

Street Address _____ Apt/Suite _____ □ SINGLE □ MARRIED □ DIVORCED □ WIDOWED
City _____ State _____ Zip Code _____
Cell Phone _____ Home Phone _____ Work Phone _____
Email Address _____ Employer _____
In case of an emergency, please provide information for the nearest relative or designated contact person:

_____ _____ _____
Name Relationship Phone #

RESPONSIBLE PARTY (If the patient is a minor or not financially responsible for the account)

Name of Responsible Party _____ Relationship to Patient _____
Date of Birth _____ SSN _____ Phone Number _____
Address (City, State, Zip Code) _____

MEDICAL HISTORY

Primary Care Physician _____ Physician Phone _____
Pharmacy Name _____ Pharmacy Phone _____
Pharmacy Address _____
Have you had any operations? □ YES □ NO If yes, please describe: _____

_____

Prescription/Over-the-Counter Medications currently taking: _____

_____

Do you have a latex allergy? □ YES □ NO

Have you had an allergic or adverse reaction to: Anesthetic? □ YES □ NO Local dental anesthetic? □ YES □ NO General/IV? □ YES □ NO
Do you have any drug allergies? □ **YES** □ **NO** If yes, please explain

_____

Are you taking or have taken any bisphosphonate drugs? (Ex: Boniva, Fosamax) □ YES □ NO
Are you taking or have taken blood thinner? (Coumadin, Platelet Inhibitors, or Aspirin Therapy) □ YES □ NO
If yes, reason why? _____

MEDICAL HISTORY- PLEASE CHECK ALL THAT APPLY

□ Anemia
□ Arthritis, Rheumatism
□ Artificial Heart Valve
□ Artificial Joints
□ Asthma
□ Back Problems
□ Bleeding Disorder
□ Cancer
□ Chemical Dependency
□ Chemotherapy
□ Circulatory Problems
□ Cortisone Treatment
□ Diabetes
□ Epilepsy
□ Fainting
□ Glaucoma
□ Headaches or Migraines
□ Heart Murmur
□ Heart Problems
□ Hemophilia
□ Hepatitis
□ High Blood Pressure
□ HIV/AIDS
□ Jaw Pain or TMJ
□ Kidney Disease
□ Mitral Valve Prolapse
□ Pacemaker
□ Radiation Therapy
□ Respiratory Disease
□ Rheumatic Fever
□ Shortness of Breath
□ Sleep Apnea
□ Stroke
□ Thyroid Problems
□ Tuberculosis
□ Ulcer
□ Other _____

For Women

Are you pregnant? □ YES □ NO
If yes, how many months? _____
Are you nursing? □ YES □ NO
Do you suspect you are pregnant? □ YES □ NO
Are you taking birth control pills? □ YES □ NO

CWE Reviewed Medical Hx: _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance. I will not hold my dentist or any member of the staff at Commonwealth Endodontics responsible for any errors or omissions.

_____ _____
Signature of patient or legal designate **Date**

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ENDODONTIC CONSENT & INFORMATION

Endodontic treatment (root canal therapy) involves cleaning, shaping, disinfecting, and filling the root canal(s) of a damaged or diseased tooth. The canal is the space inside the root, which contains developmental tissue. Although this tissue is removed, live cells remain on the outside of the root, and the body continues to recognize the tooth as alive after treatment. Multiple visits may be necessary to complete treatment.

This form serves as your consent for a Commonwealth Endodontics provider to evaluate and/or treat you as a patient. Treatment may not be initiated today. However, it is important that you are informed of the procedure(s) being considered and all potential outcomes, whether treatment occurs on this visit. Please review the following:

1. **Success Rate & Limitations**
   Root canal therapy has a 90–95% success rate; retreatment success is 80–85%. Endodontics is not an exact science, and no guarantee of treatment success can be made. Additional treatment or extraction may be needed if post-treatment issues arise.

2. **Previous Treatment**
   Endodontic treatment started or completed at other offices may have different outcomes than expected under optimal conditions.

3. **Restoration Is Required**
   After treatment, contact your general dentist promptly to schedule permanent restoration. Your restorative dentist will place either a filling or a crown on your tooth. The filling that we place for you is only temporary.

4. **Possible Complications**
   Risks include: Swelling, soreness, infection, trismus (limited opening), tissue discoloration, tooth fracture, instrument separation, root perforation, under- or overfilling of canals, sinus involvement, damage to existing dental work, blocked or curved canals, resorption, or calcifications.

   Local anesthetic is used to numb the area. Though rare, complications may include swelling, bleeding, infection, prolonged numbness or tingling (possibly permanent), muscle cramps, trismus, rapid heartbeat, and allergic reactions.

5. **Existing Restorations (Crowns, Bridges, Inlays/Onlays)**
   These restorations may need replacement after treatment if decay is present or if the restoration is compromised during access. In most cases (95%), treatment can be completed through existing restorations without issue. However, if damage occurs, the patient is responsible for replacement costs. Commonwealth Endodontics is not responsible for fabrication or payment of new restorations.

Note: All services at Commonwealth Endodontics, including root canal therapy, retreatment, and apicoectomy, are non-refundable.

By signing below, I acknowledge and accept the above risks. I consent to being evaluated by a provider at Commonwealth Endodontics and understand that if I accept the proposed treatment plan and choose to proceed, I am giving my consent for endodontic treatment to be performed, including the use of necessary anesthetics, medications, and services deemed necessary. Endodontic treatment follows accepted clinical practices, and digital images may be taken before, during, and after treatment. I also authorize the release of my dental records to my dentist and/or insurance company.

Signature of patient or legal designate **Date**

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INSURANCE, PAYMENT & CONDUCT POLICIES

At Commonwealth Endodontics, we are committed to delivering exceptional care through a safe, respectful, and professional environment. To support this, we ask for your understanding and cooperation with the following policies.

PATIENT CODE OF CONDUCT

Patients and their guests are expected to treat staff and others with courtesy, communicate respectfully, and follow all practice policies. Verbal abuse, threats, profanity, or disruptive behavior will not be tolerated and may result in immediate dismissal from the practice. Dismissed patients must arrange for their own future care. If you have concerns, please speak with our team respectfully – we're here to help.

FINANCIAL AGREEMENT & ACKNOWLEDGEMENT

Please read and initial next to the statement that applies to you:

_____ ***No dental insurance***: **I understand that full payment is due on the date of service for all services rendered.**

_____ ***With dental insurance*****:** I understand CWE will file claims on my behalf. I am responsible for the estimated co-payments at the time of service and for any balance not covered by insurance.

As a courtesy, CWE verifies insurance coverage and provides an **estimate** before your visit. **This is not a guarantee of payment**. The insurance contract is between the patient, their employer, and the insurer - CWE is not a party to it. Any remaining balance after insurance is processed will be billed. Overpayments will be refunded by check.

Please read and initial to acknowledge the following:

_____ If a tooth is deemed unsalvageable once treatment has begun, an inoperable fee of $537 will replace the full cost of your treatment and is due the same day. Insurance may not cover this service or may reimburse it at a lower rate than the planned treatment.

Additional Payment Terms*: I understand that if I do not pay on time, my account may be sent to collections. I will be responsible for all related costs, including billing, attorney, and court fees. Accounts unpaid after three statements may incur a $200 administrative process fee. Returned checks are subject to a $40 fee.*

I have read and fully understand the above insurance, payment, and conduct policies.

_____

Signature of patient or legal designate **Date**

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CONSENT TO USE DENTAL RADIOGRAPHS AND/OR DIGITAL IMAGES AND REVIEWS

To comply with the Health Insurance Portability and Accountability Act (HIPAA), we need your permission to use certain materials. Your privacy is important to us, and we value your right to control how your information is used.

Patient Information

Name (Print): _____
Date of Service: _____

Consent Options (*Please select YES or NO for each option below*):

Use of Dental Radiographs & Digital Images

Do you consent to allow Commonwealth Endodontics to use dental radiographs and/or digital images of your teeth for:

- Dental Records
- Research and Education (e.g., lectures, publications)
- Marketing (e.g., website, social media)

  - ***YES, I consent***
  - ***NO, I do not consent***

Use of Patient Reviews

Do you consent to allow Commonwealth Endodontics to use your review for marketing purposes (e.g., social media, website) Reviews will exclude personal health information.

  - ***YES, I consent***
  - ***NO, I do not consent***

I further understand that if the dental radiographs, digital images, and/or reviews are used, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these dental radiographs, digital images and/or reviews. I understand I can revoke my permission at any time by notifying Commonwealth Endodontics in writing.

_____

Signature of patient or legal designate **Date**

Thank you for helping us improve patient care and share experiences while respecting your privacy!

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____ , have received a copy of this office's Notice of Privacy Practices.

Signature: _____

Date: _____

In accordance with HIPAA privacy regulations, please list any friends or family members you authorize us to share your protected health information (PHI) with:

NAME	RELATIONSHIP	PHONE #

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual refused to sign
- □ Communication barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please specify)

_____

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PATIENT SYMPTOM ASSESSMENT

Patient Name/ Nickname: _____

Date: _____

1. What is your chief complaint? _____

2. Are you currently experiencing any pain and/or swelling? **Yes** ____ **No** ____

If yes, please specify: **Pain** ____ **Swelling** ____ **Both** ____

3. Can you locate the tooth that is causing the pain? **Right** ____ **Left** ____ **Upper** ____ **Lower** ____

4. When did you first notice the symptoms? ____**day(s)**, ____**week(s)**, ____**month(s)**, or ____**year(s)** ago.

5. Did your symptoms occur: **Suddenly** ____ **Gradually** ____

Rate your pain on a scale of 1-10: _____

6. Have you ever had pain with *this tooth* to any of the following? **Heat**____ **Cold**____ **Biting pressure**____

7. Do you grind or clench your teeth? **Yes**____ N**o**____ Do you wear a night guard? **Yes**____ **No**____

8. Has a restoration (filling or crown) been placed on this tooth recently? **Yes**____ **No**____

9. Are you currently taking antibiotics for this tooth? **Yes**____ **No**____

If yes, please tell us when you started taking the antibiotic: _____