

## PATIENT REGISTRATION

**PLEASE PRINT**

DATE: \_\_\_\_\_

NAME \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

ADDRESS \_\_\_\_\_

HOME# \_\_\_\_\_ BS# \_\_\_\_\_ CELL# \_\_\_\_\_

IF PATIENT IS A MINOR, WHO IS LEGALLY RESPONSIBLE?

\_\_\_\_\_

WHO TO CONTACT IN CASE OF EMERGENCY? \_\_\_\_\_

PHONE # \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

### DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE CO: \_\_\_\_\_ PHONE# \_\_\_\_\_

INSURANCE ADDRESS \_\_\_\_\_

SUBSCRIBER'S NAME \_\_\_\_\_

SS# \_\_\_\_\_ DOB: \_\_\_\_\_

PATIENTS RELATIONSHIP TO INSURED: \_\_\_\_\_

SUBSCRIBER'S EMPLOYER \_\_\_\_\_ POLICY/GROUP# \_\_\_\_\_

SECONDARY INSUR. INFO. \_\_\_\_\_ PHONE# \_\_\_\_\_

INSURANCE ADDRESS \_\_\_\_\_

SUBSCRIBER'S NAME \_\_\_\_\_ SS# \_\_\_\_\_

DOB \_\_\_\_\_

PATIENTS RELATIONSHIP TO SUBSCRIBER: \_\_\_\_\_

SUBSCRIBER'S EMPLOYER \_\_\_\_\_

DOB \_\_\_\_\_ SS# \_\_\_\_\_ POLICY/GROUP# \_\_\_\_\_

REFERRED BY \_\_\_\_\_ PHONE # \_\_\_\_\_

PHYSICIAN'S NAME \_\_\_\_\_ PHONE# \_\_\_\_\_

DATE OF LAST PHYSICAL EXAM: \_\_\_\_\_

IF PRESENTLY UNDER PHYSICIAN CARE – LISTS REASON.

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**Jacob Fleishman, D.D.S.**  
**PRACTICE LIMITED TO ENDODONTICS**  
101 EAST HARTSDALE AVENUE  
HARTSDALE, NY 10530

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**Endodontic Root Canal Therapy, Endodontic Surgery, Anesthetics and Medications**

**We would like our patient to be informed about the various procedures involved in endodontic therapy and have their consent before starting treatment. Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by conservative root canal therapy, or when needed, endodontic surgery. The following discusses possible risks that may occur from endodontic treatment, and other treatment choices.**

**RISKS:** Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), and injections. These complications include: swelling; sensitivity, bleeding, pain, infection; numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, which is transient but on infrequent occasions may be permanent: reaction to injection; changes in occlusion (biting); jaw muscle spasms: temporomandibular (jaw) joint difficulty; loosening of teeth; referred pain to ear, neck and head; nausea; vomiting; allergic reactions; delayed healing; sinus perforations and treatment failure.

**RISKS MORE SPECIFIC TO ENDODONTIC THERAPY:** The risks include the possibility of instruments broken within the root canals; perforations(extra openings) of the crown or root of the tooth; damage to bridges, existing filling, crowns or porcelain veneers, loss of tooth structure in gaining access to canals, and cracked teeth. During treatment complications may be discovered which make treatment impossible, or which may require dental surgery. These complications may include: blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), spills or fractures of the teeth.

**MEDICATIONS:** Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedative or other drugs) it is not advisable to operate any vehicle or hazardous device until recovered from their effects.

**OTHER TREATMENT CHOICES:** These include no treatment; waiting for more definite development of symptoms, tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infection to other areas.

**CONSENT:** I, the undersigned being the patient (parent or guardian of above minor patient) consent to the performing of procedures decided upon to be necessary or advisable in the opinion of he doctor. I also understand that upon completion of the root canal therapy in this office I shall return to my general family dentist for a permanent restoration of he tooth involved, such as a crown, cap, jacket, onlay, or silver filling.

**I understand that root canal therapy is an attempt to save a tooth, which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth, which has had root canal therapy, may require re-treatment, surgery or even extraction.**

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DATE

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WITNESS

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PATIENT/PARENT SIGNATURE

**Jacob Fleishman, D.D.S.**  
PRACTICE LIMITED TO ENDODONTICS

**Dear Patient:**

**In an effort to provide you with quality Dental Care and flexible payment arrangements, we have expanded our payment policy.**

**PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT.**

**We now offer the following payment options:**

\_\_\_\_\_ **Payment by cash**

\_\_\_\_\_ **Payment by check**

\_\_\_\_\_ **Payment by credit card (Visa, Master Card, American Express, and Discover Cards ACCEPTED.)**

**Please make your choice, sign below and return to the front desk before your visit.**

\_\_\_\_\_  
**Print your name here.**

\_\_\_\_\_  
**Patient's Signature**