ARE YOU ALLERGIC OR HAVE YOU HAD A REACTION TO:

1. Yes No… Novocaine or dental anesthetic?
2. Yes No… Penicillin or other antibiotics?
3. Yes No… Aspirin?
4. Yes No… Codeine or other narcotics?
5. Yes No… Other____

ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING DRUGS?

6. Yes No… Medicine for high blood pressure or water pills? Which?
7. Yes No… Anticoagulants or blood thinners?
8. Yes No… Insulin or drugs for diabetes?
9. Yes No… Digitalis or drugs for heart trouble?
10. Yes No… Nitroglycerin or other medicine for angina pectoris (heart or chest pain?)
11. Yes No… Cortisone (steroids)?
12. Yes No… Aspirin?
13. Yes No… Birth Control Pills?
14. Yes No… Valium, Librium or tranquilizers?
15. Yes No… Dilantin?
16. Yes No… Other medicines? What medicines? ____

WOMEN

17. Yes No… Are you pregnant or anticipating pregnancy in the near future?
18. Yes No… Are you taking hormones?

Permission for Root Canal Therapy

I, the undersigned consent to the dental procedures decided upon to be necessary or advisable in the opinion of Ian J. Langer, D.M.D. (This includes the initial examination, x-rays and consultation).

I understand that the purpose of root canal therapy is to try to save a tooth that would otherwise have to be extracted. The options of alternative treatments include extraction, or no treatment (and its risk of problems).

I also understand that only the root canal treatment, endodontic surgery and specified related procedures are to be completed at this office. The permanent restoration (crown or filling) is to be performed by my general dentist.

I understand that root canal therapy cannot be guaranteed to be successful. Success is generally expected in most cases, and if chance for success is not good, I will be so informed. That problems may arise beyond the control of Dr. Ian Langer, including but not limited to: broken instruments in the root canal, paresthesia (numbness or “pins and needles” feeling from the anesthetics), fractures, pain and swelling.

I understand that I am responsible to make and keep all appointments for treatment, and that failure to complete treatment in a timely manner may result in lost temporary fillings, reinfection, pain, swelling, fracture and the possible loss of the tooth. This may then give rise to additional necessary treatment and additional fees.

I agree to be fully responsible for payment of the fees charged which will be stated before treatment begins, and have read the office policy on fees. I will be responsible for additional fees for broken appointments, and additional procedures necessitated by prolonging treatment.

Signature____Date________________________

Employer____Position______________________

Insurance information: Primary____

Secondary____

Please note: This office does participate in many dental insurance programs but not in all plans. As some plans will not make payments to this office, please verify your insurance coverage before treatment and please speak with our receptionist. Payment is expected at time services are rendered unless other arrangements have been made in advance. Since treatment may take several visits, payments may be made over the course of treatment and is to be paid in full by the final appointment. We will be glad to help you fill out and submit the insurance forms so that your insurance benefits will be paid to you.