Date

Patient:'s Name (please print)

Mailing Address

City

State Zip

Physical Address

City

State Zip

❑ Single ❑ Married Sex: ❑ Male ❑ Female

Email

Patients Age

Home Phone Date of Birth

Cell Phone Soc. Sec. No.

Work Phone Driver's Lic. No.

Patient's Occupation

Patients's Employer

General Dentist

FINANCIALLY RESPONSIBLE PERSON IF OTHER THAN PATIENT OR SPOUSE

First Name Middle intl. Last Name

Address

City State Zip

Sex: ❑ Male ❑ Female

Soc. Sec. No. Driver's Lic. No.

Home Phone No. Date of Birth

Cell Phone Work Phone No.

Occupation

Employer

Address

City State Zip

Have you ever been treated in our office before? ❑ Yes ❑ No

If patient is over 18 years old and is a full time student:

Name of School

City

Primary Dental Insurance

Name of Insurance Company

Address

City

State Zip

ID/Agreement No. Group Name or No.

Subscriber's Name on Insurance coverage *(if different from patient's)*

Date of Birth Soc. Sec. No.

Employer's Name

Address

How is this employee related to the patient?

❑ Subscriber ❑ Spouse ❑ Dependent

Secondary Dental Insurance

Name of Insurance Company

Address

City

State Zip

ID/Agreement No. Group Name or No.

Subscriber's Name on Insurance coverage *(if different from patient's)*

Date of Birth Soc. Sec. No.

Employer's Name

Address

How is this employee related to the patient?

❑ Subscriber ❑ Spouse ❑ Dependent

I agree to be responsible for any charges not paid by my insurance company or if I am not covered by insurance.

Date Signature

PLEASE COMPLETE BACK SIDE OF THIS FORM

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

1. Yes / No Is your general health good?
   If NO, explain: _____
2. Yes / No Has there been a change in your health within the last year?
   If YES, explain: _____
3. Yes / No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
   If YES, explain: _____
4. Yes / No Are you being treated by a physician now? If YES, explain: _____
   Date of last medical exam? _____ Reason for exam: _____
5. Yes / No Have you had problems with prior dental treatment?
   If YES, explain: _____
   Date of last dental exam? _____ Name of last dentist: _____
6. Yes / No Are you in pain now?
   If YES, explain: _____

II. DO YOU HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Heart disease	Yes / No AIDS/HIV	Yes / No Psychiatric care
Yes / No Heart attack	Yes / No Surgeries	Yes / No Osteoporosis
Yes / No Heart defects	Yes / No Hospitalization	Yes / No Thyroid disease
Yes / No Heart murmurs	Yes / No Diabetes	Yes / No Asthma
Yes / No Hardening of arteries	Yes / No Tumors or cancer	Yes / No Hepatitis
Yes / No High blood pressure	Yes / No Transplants	Yes / No STDs

Yes / No Artificial joint	Yes / No Chemotherapy	Yes / No Herpes
Yes / No Stomach problems or ulcers	Yes / No Radiation	Yes / No Canker or cold sores
Yes / No Rheumatic fever	Yes / No Arthritis, rheumatism	Yes / No Anemia
Yes / No Skin disease	Yes / No Emphysema/lung disease	Yes / No Liver disease
Yes / No Seizures	Yes / No Kidney or bladder disease	Yes / No Eye disease
Yes / No Stroke	Yes / No Eating disorders	Yes / No Tuberculosis

Others: _____

III. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Aspirin	Yes / No Valium or sedatives	Yes / No Codeine or other opioids
Yes / No Penicillin or other antibiotics	Yes / No Latex	Yes / No Food
Yes / No Nitrous oxide	Yes / No NSAIDS	Yes / No Local anaesthetic
Yes / No Metal		

Others: _____

IV. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? (Please circle Yes or No for each)

Yes / No Aspirin
Yes / No Antibiotics
Yes / No Bisphosphonate (Fosamax)
Yes / No Opioids (e.g., Norco, Vicodin, Percocet, Percodan) If YES, please explain reason: _____

Please list all prescription medications:

V. WOMEN ONLY (Please circle Yes or No for each)

Yes / No Are you or could you be pregnant? If YES, what month?
Yes / No Are you nursing?
Yes / No Are you taking birth control pills?

VI. ALL PATIENTS (Please circle Yes or No for each)

Yes / No Do you have or have you had any other disease or medical problems NOT listed on this form?
If YES, please explain:

Yes / No Do you require premedication (antibiotic) for dental treatment? If YES, why:
Yes / No Have you ever taken Fen-Phen? If YES, when:
Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?**

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: Date:

Physician's Name: Date:

Whom would you like us to contact in case of an emergency? :
Name: **Relationship:** **Phone Number:**

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

TAD
SUZ
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DDS

WELCOME TO OUR OFFICE

Patient comfort is our primary concern. Our goal is to alleviate apprehension and to provide the finest care. Every patient is important to us and benefit from the most advanced technology available for endodontic treatment. In our office we use a surgical operating microscope which offers increased magnification and illumination for all procedures.

BASIC ENDODONTIC OBJECTIVES: Endodontic treatment consists of cleaning, shaping and filling the internal root canal space of a tooth. The number of appointments needed to accomplish this varies, depending upon: which tooth is treated; amount of infection or pain initially present; complexity of the case; and each individual's healing response. Normally, most teeth can be completed in one or two visits using the gentle wave procedure.

The goal of root canal treatment is to save a tooth that might otherwise require extraction. Although root canal treatments have a high rate of success, as with all medical and dental procedures, this success cannot be guaranteed. Occasionally, a tooth that has had previous root canal treatment may require re-treatment, surgery, or extraction.

HEALTH HISTORY: All patients or parents of a minor child will be asked to complete a brief medical history form.

CONSULTATION: A diagnostic X-ray will be taken, and the doctor will examine and test the tooth/teeth in question, as well as the surrounding tissues. Treatment of the case will be discussed.

DENTAL INSURANCE: We will bill all insurance companies as a courtesy to our patients. Any questions about insurance should be discussed with our office before that start of treatment. It is your responsibility to be informed about your insurance benefits. Our office will do its best to obtain your insurance benefits to inform you of the out-of-pocket expenses. You are responsible for any amounts which are not covered by your insurance.

METHOD OF PAYMENT: All payments are due at the start of treatment. If you do not have dental insurance and wish to pay with cash or check, a discount will be given.

Please indicate which of the following methods of payment you will be using:

☐ **CASH** ☐ **CHECK** ☐ **VISA, MASTERCARD, or DISCOVER** ☐ **AMEX**

DELINQUENT ACCOUNTS: A service charge of 0.83% per month / 10% per annum (but in no event more than the maximum rate permissible under state law) will be charged on any unpaid balance due from the patient at the time of service. **Any patient balance inactive for 60 days will automatically be turned over to our collection agency.**

FINAL RESTORATIONS: I understand that upon completion of my root canal therapy in this office, I will be directed to return to my general dentist should I need permanent restoration such as a crown or filling. Failure to place the recommended final restoration in a timely manner (no more than 4 weeks) on a completed root canal treated tooth can result in tooth fracture or recurrent decay, which in turn can result in failure of the root canal and eventual need for retreatment or extraction. I understand that I will be responsible for any re-work or re-treatment.

LAB FEES: If it is necessary for us to order a laboratory test (such as culture or biopsy), you will be billed directly by them and are responsible for the payment of that bill.

AGREEMENT: As a patient or legal guardian of a minor patient. I agree to pay for all services rendered in accordance with the terms and conditions set forth in the financial policy. In the event that legal action should become necessary to enforce payment of any charges, I agree to be responsible for all reasonable legal cost incurred.

Date	Patient or Guardian's Signature

Tad Suzuki, DDS Microsurgical Endodontics admin@suzukidds.com 805 – 770 – 3330

CONSENT AND INFORMATION FORM

Regarding Health History, Endodontic (Root Canal) Treatment, Medications, & Local Anesthetic

Dr. Suzuki and his staff will inform you of any treatment needed. It is the belief of this office that you should be informed about any and all treatment, and that you should give your consent before starting that treatment. The purpose of this consent is to communicate the risks that may occur with endodontic treatment, as well as other treatment choices. There are two kinds of risks: those risks involved in general dental procedures, and those risks specific to endodontic treatment.

RISKS OF DENTAL PROCEDURES IN GENERAL: include but are not limited to complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness, and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, thrombophlebitis (inflammation to a vein), reaction to injections, change in occlusion, muscle cramps and spasm, temporomandibular (jaw) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues, referred pain to the ear, neck and head, nausea, vomiting, allergic reactions (itching, bruises, delayed healing, sinus complications, and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY: These risks include instruments broken within the root canals, perforations (extra openings) of the crown or root of the tooth, damage to bridges, existing fillings, 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, prior treatment, natural calcification, broken instruments, curved roots, periodontal disease (gum disease), splits or fractures of teeth.

OTHER TREATMENT CHOICES: include no treatment, waiting for more definite development of symptoms, having the tooth removed, obtaining a second opinion. Risks involved in these choices might include pain, swelling, infection, and loss of tooth. Treatment will be done in a manner to minimize or avoid risks as success cannot be guaranteed.

I understand that upon my request I may receive a copy of this form. I, the undersigned, being the patient or guardian of minor patient, consent to the performing of the procedures decided upon to be necessary or advisable in the opinion of the doctor on the tooth or tissues as listed.

Date	Patient or Guardian's Signature

Date Reviewed By:

Tad Suzuki, DDS Microsurgical Endodontics admin@suzukidds.com 805 – 770 – 3330

MICROSURGICAL ENDODONTICS

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

Protected health information may be disclosed or used for treatment, payment, or healthcare operations.

- ☐ The practice reserves the right to change the privacy policy as allowed by law.
- ☐ The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- ☐ The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- ☐ The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES / NO

May we leave a message on your answering machine at home or on your cell phone? YES / NO

May we discuss your medical condition with any member of your family? YES / NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

admin@suzukidds.com ● 805.770.3330 ● www.suzukidds.com
122 S. Patterson Ave. Bldg. B Ste. #107 Santa Barbara, CA 93111

Gentle Wave PROCEDURE

PROCEDURE FEE LETTER

Tad Suzuki, DDS Microsurgical Endodontics. Offers the Gentle Wave® Procedure. This procedure elevates root canal cleaning and disinfection and uses a minimally invasive[1-4] protocol that reduces postoperative pain[5] and promotes fast healing for patients[6]. In most cases, the Gentle Wave Procedure can be completed in one appointment[3].

Dr. Suzuki will first determine if you are a candidate for the Gentle Wave Procedure by ensuring you meet the eligibility criteria. If it is determined that your tooth is suitable for the Gentle Wave Procedure, Dr. Suzuki and staff will provide you with detailed information explaining the Gentle Wave Procedure.

Because the Gentle Wave Procedure does not currently have a specific code for billing your dental plan, your plan will not pay for it. Since dental plans do not cover the Gentle Wave Procedure, the fee will be your responsibility. You will be liable for the payment of **$150.00**. We can provide additional information should you require it, but we find that the majority of patients prefer the Gentle Wave Procedure.

You should:

1. Read this notice so you can make an informed decision about your care.
2. Ask us any questions that you may have after you finish reading.
3. Choose an option below about receiving the Gentle Wave Procedure.

- ☐ I want the Gentle Wave Procedure and I understand that I am responsible for payment and that the payment of **$150.00** is due at the start of treatment.
- ☐ I do not want the Gentle Wave Procedure.

Signing below means you have received and understand this notice.

Signature: _____ Date: _____

TAD SUZ UKI DDS