Date _____

Last Name _____ First _____ Middle _____

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other _____ Social Security # _____

Address _____ Home Phone _____

City _____ Zip Code _____ Business Phone _____

Occupation _____ Date of Birth _____

Place of Business _____

Referring Dentist _____

Parent, Spouse Name _____

Are you in good health? ☐ Yes ☐ No If no, why? _____

Are you under medical care? ☐ Yes ☐ No If yes, why? _____

List medication(s) you are taking _____

_____

List sensitivity or allergy to medication(s) _____

Physician's Name _____ Phone _____

Address _____

_____

Which of the following apply to you:

Yes	No	Unsure		Yes	No	Unsure		Yes	No	Unsure	
☐	☐	☐	Pregnant	☐	☐	☐	HIV Positive	☐	☐	☐	Swollen Joints
☐	☐	☐	Diabetes I	☐	☐	☐	Arthritis	☐	☐	☐	High blood pressure or hypertension
☐	☐	☐	Diabetes II	☐	☐	☐	Stomach Ulcers	☐	☐	☐	Anemic or blood disorders
☐	☐	☐	Allergies	☐	☐	☐	Rheumatic fever or Rheumatic heart disease	☐	☐	☐	Shortness of breath or difficulty in breathing
☐	☐	☐	Tuberculosis	☐	☐	☐	Syphilis	☐	☐	☐	Pains in arms, legs, or chest
☐	☐	☐	Do you have a persistent cough?	☐	☐	☐	Tumor, cyst, cancer, other growths	☐	☐	☐	Heart problem
☐	☐	☐	Do you cough up blood?	☐	☐	☐	Major operation or surgery	☐	☐	☐	Fainting or dizzy spells
☐	☐	☐	Hepatitis, jaundice or liver disease	☐	☐	☐	Kidney disease	☐	☐	☐	Drug or alcohol abuse history
☐	☐	☐	Ear infections, or noise	☐	☐	☐	Other				
☐	☐	☐	AIDS	☐	☐	☐	Prosthetic Joints				
☐	☐	☐	Heart Murmur								

Is there anything you think is important for us to know? _____

_____

_____

_____

_____

CHARGES ARE PAYABLE AT TIME OF TREATMENT

Patient Signature (Parent or Guardian of Minor) _____ Date _____

Update _____ (patient must initial & date)

Update _____ (patient must initial & date)

Update _____ (patient must initial & date)

PAYMENT POLICY

Full payment is expected on/or prior to the completion of treatment. Payment arrangements made in advance, such as dental insurance, are also acceptable. Patients having insurance plans other than Delta Dental of Michigan or Blue Cross and Blue Shield are responsible for any portion of the fee not paid by their insurance company as many of these other insurance companies do not pay the usual and customary fees.

Root Canal Fee Schedule:	Anterior Teeth	Bicuspid Teeth	Molar Teeth
	$745-1,300	$825-1,600	$970-1,900

More difficult cases sometimes require endodontic surgery. This is a separate procedure and the fees range from $1000-2100. Patients are advised if this treatment is necessary.

For those patients requiring periodontal treatment, fees are set and discussed individually.

Patient Name _____ Payment Type: ❑ Cash ❑ Visa/Mastercard/Discover

Date of Birth _____ ❑ Check ❑ Care Credit

Cardholder's Name _____

Primary Dental Insurance _____ Birth Date _____

Employer _____ Social Security # _____ Group # _____

Secondary Dental Insurance _____ Cardholder's Name _____

Employer _____ Social Security # _____ Group # _____

Signature (person responsible for account) _____ Date _____

FRANKLIN L. GORDON, JR., D.D.S., M.S., M.S., P.C.
Endodontist and Periodontist

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Flint, Michigan 48532
Telephone (810) 230-0990

1974 North Huron River Drive, Suite 200
Ypsilanti, Michigan 48197
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CONSENT FOR ENDODONTIC PROCEDURES

Diagnosis, Recommended Treatment and Expected Benefits. After a careful oral examination and study of my dental condition, my endodontist has advised me that I am in need of endodontic treatment. I understand that endodontic (root canal) therapy is performed in an attempt to save a tooth which otherwise might need to be extracted (removed).

Principal Risks and Complications. 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: swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, which is transient but on rare occasions may be permanent, reaction to injections, changes in occlusion (biting), jaw muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth, referred pain to ear, neck and head, nausea, vomiting, allergic reactions, delayed healing, and treatment failure.

Risks More Specific to Endodontic Treatment. 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 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 or prior treatment, natural calcifications, broken instruments, curved roots periodontal disease (gum disease), splits or fractures of the teeth.

Medications. Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be intensified by the use of alcohol, tranquilizers, sedatives or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from the effects of the medications and drugs.

Alternatives to Suggested Treatment. Other treatment choices 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.

PATIENT CONSENT

I, the undersigned, being the patient, parent or guardian, consent to the performing of procedures decided upon to be necessary or advisable in the opinion of my endodontist. I also understand that upon completion of root canal therapy in this office, I shall return to my general dentist for a permanent restoration of the tooth involved, such as a crown, cap, jacket, onlay or silver filling. I realize that a check up x-ray should be taken in twelve (12) months by my own general dentist or by my treating endodontist.

Although root canal therapy has a very high degree of clinical success, it is still a biological procedure and cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery or even extraction. My questions have been answered to my satisfaction. I have carefully read the above statements and give my consent for the procedure.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

_____ Date

_____ Signature of Patient, Parent or Guardian

_____ Date

_____ Signature of Witness

INFORMED CONSENT FOR SURGICAL ENDODONTICS

I understand that the purpose of this procedure is to surgically treat and correct the inflammatory or diseased condition around the root of my tooth. Although surgical endodontics has a very high degree of clinical success, it is still a biological procedure and cannot be guaranteed.

As with all surgery, there are risks which may accompany this procedure. Some of these risks are: infection, necrosis (if taking bisphosphonates), swelling, discomfort, gum recession (shrinkage) over the involved tooth, bleeding under the skin causing discoloration on the face, amalgam tattoo, and paresthesia (numbness or tingling), in the area of the lip and gum which, although quite rare, may be permanent.

I further understand that if treatment is not rendered, my present condition may possibly deteriorate, resulting in the loss of my tooth and damage to surrounding tissues.

I have carefully read the above statements about endodontic surgery. My questions have been answered to my satisfaction, and I give my consent to the procedure.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS DOCUMENT.

Date	Signature of Patient, Parent or Guardian
Date	Signature of Witness

Franklin L. Gordon, Jr., D.D.S., M.S., M.S., P.C.

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigations; an identifications of a dead body; a licensure investigation; or a child abuse/neglect investigations.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment

Patient Acknowledgement

Please sign this form below under the heading "acknowledgement" to acknowledge that you have today received a copy of our notice of privacy practice.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

_____ _____

Patient Signature Patient Name (please print)

Date:_____

For office use only

Patient Refused to Sign

The following circumstances prohibited the patient from signing the Acknowledgment:

_____

An emergency situation prevented the patient from signing the Acknowledgment:

_____ _____

Office Personnel (signature) Office Personnel (print name)

Date:_____

Patient Consent

Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

_____ _____

Patient Signature Patient Name (please print)

Date:_____