Louis G. Karras, DDS, PC - Endodontics

PATIENT INFORMATION

REFERRING DENTIST: DR. ______________________________

FIRST NAME __________________________ MI ______ LAST NAME ______________________________

ADDRESS ____

CITY _________________________ STATE ________ ZIP ______________

DATE OF BIRTH ______/______/_______ SS# ________-______-__________

TEL (______) ______ - _________ ☐ HOME ☐ CELL ☐ WORK

(______) ______ - _________ ☐ HOME ☐ CELL ☐ WORK

☐ MALE
☐ FEMALE

☐ MINOR (CHECK IF UNDER AGE 18)

☐ SINGLE
☐ MARRIED
☐ PARTNERED
☐ SEPARATED
☐ DIVORCED
☐ WIDOWED

DENTAL INSURANCE - POLICY HOLDER'S INFORMATION

RELATION TO PATIENT: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ PARTNER

FIRST NAME __________________________ MI ______ LAST NAME ______________________________

DATE OF BIRTH ______/______/_______ SS# ________-______-__________

EMPLOYER ______________________________________ BUS. TEL (______) ______ - ________

INSURANCE CO ______________________________________

GROUP/POLICY # ________________________ MEMBER ID# ____________________________________

FEES AND PAYMENTS - ASSIGNMENT OF BENEFITS

Payment is due at the time of service. We accept cash, check, and credit card (Visa, MasterCard, Discover)
Patients with Insurance: We will gladly work with your insurance to obtain benefit verification; this is not a guarantee of payment. Contract and plan limitations may apply. Estimated deductible and co-payments are due in full at the completion of each visit. My signature on file authorizes the submission of insurance claims for services provided, the release of any necessary information for processing such claims, and hereby authorizes payment to Louis G. Karras, DDS, PC of the benefits otherwise payable to me.
I understand that I am financially responsible for any and all charges not covered by my dental insurance.

I have read and understand the Policies above. ____ Today's Date ____/____/_____
PATIENT'S SIGNATURE (IF PATIENT IS A MINOR, PARENT/GUARDIAN SIGNATURE IS REQUIRED)

CONSENT FOR ROOT CANAL EVALUATION & TREATMENT

I hereby give my consent for endodontic (root canal) evaluation and treatment. I understand the following:

1. As a rule, **95%** of routine root canal cases are **successful,** however, like most other procedures it is NOT an exact science and is NOT 100% successful. Thus, no guarantee of treatment success is given or implied.
2. A temporary filling is usually placed by the endodontist at the completion of the root canal. The tooth will need a permanent filling and possibly a post and crown. I understand that it is my responsibility to contact my referring dentist to arrange for this permanent restoration within a few weeks.

I understand that endodontic therapy may have the following complications: possible fracture of crown or root; acute abscess including swelling, pain, fever; procedural difficulties including separated endodontic instruments in the canal, inability to locate/ treat canals, perforation of tooth or roots in search of canal; additional unknown or unspecified problems, of which the explanation and responsibility cannot be given or assumed.

Patient's Signature ____ Today's Date ____/____/_____

***If Patient is a Minor**, Parent/Guardian signature is **required** above*
Relation to Patient __________________ Parent/Guardian's Name ____________________ ___________________________
First Last

6677 North Lincoln Avenue Suite 100 Lincolnwood, IL 60712 (847) 677-3636 www.drkarrasendo.com

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MEDICAL HISTORY

DO YOU CURRENTLY HAVE OR HAD ANY OF THE FOLLOWING?

Y	N		Y	N		Y	N	
☐	☐	HIGH BLOOD PRESSURE	☐	☐	DIABETES	☐	☐	ARTHRITIS
☐	☐	LOW BLOOD PRESSURE	☐	☐	DELAY IN HEALING	☐	☐	JOINT REPLACEMENT (HIP, KNEE, ETC)
☐	☐	CHEST PAIN / ANGINA	☐	☐	KIDNEY DISEASE	☐	☐	OSTEOPOROSIS
☐	☐	HEART ATTACK	☐	☐	DAILYSIS SHUNT	☐	☐	ANEMIA
☐	☐	HEART SURGERY	☐	☐	EPILEPSY / CONVULSIONS	☐	☐	BLEEDING DISORDER
☐	☐	HEART MURMER	☐	☐	HEPATITIS	☐	☐	STOMACH ULCERS
☐	☐	MITRAL VALVE PROLAPSE	☐	☐	JAUNDICE / LIVER DISEASE	☐	☐	FAINTING SPELLS
☐	☐	ARTIFICIAL HEART VALVE	☐	☐	HIV POS / AIDS	☐	☐	ASTHMA
☐	☐	RHEUMATIC FEVER	☐	☐	IMMUNOSUPPRESSED	☐	☐	HAY FEVER / SINUS PROBLEMS
☐	☐	PACEMAKER	☐	☐	EMPHYSEMA	☐	☐	TUMORS / CANCER
☐	☐	ATRIAL FIBRILLATION	☐	☐	TUBERCULOSIS	☐	☐	SEXUALLY TRANSMITTED DISEASE
☐	☐	STENT (CORONARY)	☐	☐	HYPOGLYCEMIA	☐	☐	EMOTIONAL–NERVOUS DISORDER
☐	☐	ENDOCARDITIS	☐	☐	STROKE / ANEURYSM			

OTHER CONDITIONS, SYMPTOMS, CONCERNS: ______________________________

WOMEN ONLY

IS THERE A POSSIBILITY OF PREGNANCY? ☐YES ☐NO IF YES, EXPECTED DELIVERY DATE: ____/____/______

ARE YOU NURSING? ☐YES ☐NO

ARE YOU TAKING BIRTH CONTROL PILLS? ☐YES ☐NO NOTE: SOME ANTIBIOTICS MAY ALTER THE EFFECTIVENESS OF BIRTH CONTROL PILLS

ALLERGIES

ARE YOU ALLERGIC OR HAD A REACTION TO ANY OF THE FOLLOWING?

Y	N		Y	N		Y	N	
☐	☐	LATEX, PLASTICS	☐	☐	PENICILLIN, AMOXICILLIN, AUGMENTIN	☐	☐	ASPRIN, IBUPROFEN
☐	☐	SULFA DRUGS, SULFITES	☐	☐	NOVOCAINE, LOCAL ANESTHETIC	☐	☐	CODEINE, VICODIN
☐	☐	IODINE	☐	☐	METALS (JEWELRY)			

OTHER: ______________________________

MEDICATIONS

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

Y	N		Y	N	
☐	☐	BLOOD THINNERS (COUMADIN, WARFARIN, ASPIRIN)	☐	☐	BONE DENSITY DRUGS (FOSAMAX, ZOMETA,ACTONEL AREDIA, BONIVA)
☐	☐	INSULIN	☐	☐	STIMULANTS (PHENTERMINE, METHAMPHETAMINE)
☐	☐	STEROIDS	☐	☐	APPETITE SUPPRESSANTS (FEN-PHEN, REDUX)
☐	☐	PAIN KILLERS			

LIST ANY MEDICATIONS, DRUGS OR SUPPLEMENTS YOU ARE CURRENTLY TAKING: ______________________

I certify that I have read and answered the questions of this “Registration Form” (consisting of two sides) to the best of my ability. I will not hold Dr. Louis G. Karras, or any other member of this office, responsible for any omissions or errors that I may have made in the completion of this “Form.”

Patient’s Signature ______________________________ Today’s Date ___/___/____

***If Patient is a Minor**, Parent/Guardian signature is **required** above*

Relation to Patient __________________ *Parent/Guardian’s Name* __________________ __________________

First *Last*