

Allan Moskow D.D.S., P.A.
Practice Limited to Endodontics
2240 Woolbright Rd., Suite 410 Boynton Beach FL 33426

Patient Information:

Patient Name: _____ Birth date: _____
Address: _____ Social Security #: _____
City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Cell or Work #: _____
Employer: _____ Occupation: _____
Spouse or Parent: _____ Marital Status: S M D W
Referred By: _____

Dental Insurance Information: (Insurance will be handled on an individual basis depending upon the plan)

Name of Dental Insurance: _____ Phone #: _____
Subscriber Name: _____ ID or Social Security #: _____

Your insurance company DOES NOT guarantee payment. If after 45 days we do not receive payment from your insurance, you will become responsible for the balance. Please initial _____

Dental History:

Do you require antibiotic premedication prior to dental treatment? Yes No
Are you allergic to any dental material? Yes No If yes, please specify: _____
Have you ever fainted or had bleeding from dental treatment? Yes No
Do you have pain or clicking in jaw-joint area? Yes No

Medical History:

Please answer all the questions to the best of your ability. Anesthetics and other medications that may be necessary in your dental treatment may interact with prescriptions, over the counter drugs, medications and illicit drugs.
These Interactions May Be Serious. You must disclose if you are a recovering alcoholic or drug user.

1 Are you in good health Yes No

2 Have there been any changes in your general health within the year? Yes No

3 Date of last physical exam: _____

4 Physicians Name: _____

City: _____

Phone: _____

5 Are you under the care of a physician? Yes No

6 Have you ever been hospitalized for any surgical operation or serious illness? Yes No

Please explain: _____

7 Are you taking any medicine(s), including non-prescription medicine? Yes No

If yes, what medicine(s): _____

8 Are you allergic to or have you had reactions to:

Penicillin Yes No

Other antibiotics Yes No

if so, please list: _____

Codeine Yes No

Aspirin Yes No

Sulfa drugs Yes No

Dental anesthetic (novacaine) Yes No

Other: _____

Have you ever had or are you currently being treated for:

Rheumatic fever or disease	Yes	No	Heart trouble	Yes	No
Congenital heart disease	Yes	No	Heart attack	Yes	No
Mitral valve prolapse	Yes	No	Angina	Yes	No
Artificial heart valve	Yes	No	By-pass surgery	Yes	No
Abnormal heart beats	Yes	No	Stroke	Yes	No
Do you wear a pacemaker?	Yes	No	High blood pressure	Yes	No
Emphysema	Yes	No	Bronchitis	Yes	No
Asthma	Yes	No	TB or other: _____	Yes	No
Kidney Problems or dialysis	Yes	No	Epilepsy	Yes	No
Seizures	Yes	No	Fainting spells	Yes	No
other neurological disease	Yes	No	Problems with mental health?	Yes	No
Cancer or tumor	Yes	No	Radiation or chemotherapy	Yes	No
Thyroid disease	Yes	No	Ulcers or gastrointestinal disease	Yes	No
Sinus problems	Yes	No	Sexually transmitted disease	Yes	No
Arthritis	Yes	No	Diseases of bones or joints	Yes	No
Abnormal bleeding problems	Yes	No	Blood transfusion	Yes	No
Diabetes	Yes	No	AIDS or HIV infection?	Yes	No
Hepatitis (which type?) _____	Yes	No	Jaundice or Liver disease	Yes	No

Do you have any impairment or disorder of your eyes _____ ears _____ nose _____ or throat _____
 Do you have any disease, condition or problem not listed above that you think I should know about?
 If so, explain: _____

For Women Only:

Are you pregnant? Yes No If so, what month? _____ Are you nursing? Yes No
 Are you taking birth control pills? Yes No Certain Medications can interfere with their effectiveness.

This is to certify that I have answered the above questions to the best of my knowledge and my medical history is true and correct.

PLEASE READ:

At the first visit you will be advised as to the expected outcome, the number of appointments needed, what you may expect from treatment and alternative treatment options. Fees are quoted in advance of the treatment. The office policy is that payment in full must be completed by the last visit. Any problems regarding payment must be discussed with the receptionist prior to the completion of treatment. When treatment is completed your tooth will need a final, permanent restoration or filling. The root canal fee does not include this service. Temporary filling will be placed in your tooth until you return to your dentist who will permanently restore the tooth.

Date

Signature of Patient

Date

Signature of Dentist

Patient Screening Form

ADA®

Patient Name: _____

	PRE-APPOINTMENT	IN-OFFICE
	Date: _____	Date: _____
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? <i>Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.</i>	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days?	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of [State and Territorial Health Department Websites](#) for your specific area's information.

X _____

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DIPLOMATE, AMERICAN BOARD OF ENDODONTICS
PRACTICE LIMITED TO ENDODONTICS

Woolbright Professional Building ♦ 2240 Woolbright Rd., Suite 410 ♦ Boynton Beach, FL 33426 ♦ (561) 738-6251

ENDODONTIC INFORMED CONSENT

The Florida Medical Consent Law requires doctors to advise patients of the general nature of treatment or procedures, the medically acceptable alternative procedures or treatments, and the substantial risks inherent in the proposed treatment or procedures. In signing this consent form, you are agreeing that you have been advised of these matters to your satisfaction and understand that one alternative is not to have any treatment at all with a full understanding of the risks and hazards of declining treatment.

Endodontics (root canal) therapy is performed in order to try to save a tooth which might otherwise needed to be removed. This is accomplished by conservative root canal therapy or when needed, endodontic surgery.

I, _____, have been advised that I require root canal therapy for my tooth # _____.

I have been informed of the method and manner of the proposed treatment, the advantages of root canal therapy compared to extraction and the consequences of not having any treatment at all. I am also aware of the possible risks that may occur from endodontic treatment:

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.

RISKS: Included (but not limited to) are complications resulting from the use of dental instruments drugs, 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 infrequent 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, 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 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 influenced by the use of alcohol, tranquilizers, sedatives or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effects.

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 the doctor. I also understand that upon completion of root canal therapy in this office I shall return to my general family dentist for a permanent restoration of the tooth involved, such as a crown, cap, jacket, onlay or silver filling.

I understand that root canal treatment 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 retreatment, surgery or even extraction.

DATE

WITNESSED BY:

PATIENT/PARENT SIGNATURE

DOCTOR SIGNATURE

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BOYNTON BEACH, FLORIDA 33426
TELEPHONE (561) 738-6251

Consent

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I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature: _____ Date: _____

Patient, parent or legal guardian

If signed by patient representative, state relationship to patient _____

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Cone Beam Computed Tomography

Cone beam computed tomography is an innovative imaging technique that provides us

With three-dimensional view of a tooth and enhanced our ability to diagnose, evaluate, treat and
Care for patients.

During a CBCT scan, the machine rotates around the patient, capturing images using a cone shaped
x-ray beam. These images are then used to construct a 3-D representation of the patient's tooth which
gives us information not seen on a 2D xray . We have an improved version of a CBCT machine which
greatly reduces the amount of radiation received from a CT unit compared to those found in a hospital
or imaging center. It produces about the same level of radiation which would be produced in about
two dental xrays.

We may need to take a CBCT scan on certain teeth in order to better diagnose and treat them. Included
In this are teeth that have had previous endodontic therapy but have failed to heal, Teeth that have had
The canal space calcified or have unusual internal anatomy, teeth that have suffered a traumatic injury.
Teeth that have resorption present, and several other situations.

If we feel that a CBCT is useful in your specific case we will inform you. There will be an additional
Charge to your endodontic therapy is we decide a CBCT scan will be useful to the diagnosis or treatment
of your endodontic therapy.

If you have insurance, some policies will pay for a scan , while some may not. We previously sent our
Patients out to imaging centers or surgical offices to obtain a scan but found that many were charging
Fees in the range of \$350 to obtain them and by having it done in our office we have been able to offer
Our patients roughly a 50% reduction in the fee . If we feel that a scan will be useful to your specific
endodontic diagnosis or treatment you will be Informed in advance.

X

EDUCATION FOR PATIENTS REGARDING OPIOID USE

The decision to take prescription opioids is your choice. Prescription opioids can be used to help relieve moderate to severe pain when recovering from a surgery. Medications are an important part of your treatment and you should work closely with your prescribing doctor to understand the risks and benefits of taking any medications, including opioids. Knowing your options for pain management is important. Pain relievers such as acetaminophen, ibuprofen and naproxen may be the best choice and have fewer risks and side effects. Opioid use can have a number of side effects such as:

- Nausea, vomiting or dry mouth
- Sleepiness and dizziness
- Confusion
- Depression
- Itching and sweating
- Constipation
- Addiction
- Opioid overdose can cause slowed breathing and even be fatal

If you discuss all your pain management options and risks with your doctor and you decide taking a prescribed opioid is the best choice for your pain management:

- Understand all the risks and side effects of opioid use (Additional resources can be found on the CDC and FDA websites www.fda.gov and www.cdc.gov).
- Always take the prescribed opioid as directed by your prescribing doctor and never take more than your doctor ordered, or more frequently than your prescribing doctor ordered.
- Never use another person's prescription opioids or share, sell or trade your own prescription opioids.
- Do not take other medications or prescribed opioids from other doctors without informing them of any and all medications you are taking and any potential drug interactions.
- Report any and all medications and health issues to your prescribing doctors before taking opioids and bring the pill bottle with you to any hospital or doctor's visits.
- Report any addiction problem to your doctor.
- The prescribing doctor will prescribe an appropriate number of pills to manage your pain. If your medicine is lost, stolen or used up sooner than prescribed, your medication may not be replaced. If a refill is required, contact your doctor's office during normal business hours. No refills will be provided on nights, holidays or weekends.
- Properly dispose of any unused prescription opioids

Your doctor may consult the state Prescription Drug Monitoring Program (PDMP) before prescribing you opioids.

My signature below acknowledges I have read and understand the information provided to me and my questions have been answered.

Patient's (or Legal Guardian's) Signature

Date

Print Patient's (or Legal Guardian's) Name/Relationship

Date