Timothy H. Mihle, D.D.S.

Patient Information: **Date:_____**

Name:

_____
Last First M Date of Birth SS#

Circle:

Married Widowed Single Minor Male Female

Address:_____
Street Apt# City State Zip

Mailing Address:_____
Street/P.O. Box Apt# City State Zip

Telephone_____
Home Work Cell

E-Mail:_____

If the patient is under 18 years of age:

Name of Parent bringing child to today's appointment:

_____SS#_____

Mailing Address:_____
Street/P.O. Box Apt# City State Zip

Telephone:_____
Home Work Cell

Dental Insurance Information:

Primary Insured Member Employer_____

Name_____SS#_____Date of Birth_____

Primary Dental Insurance Co._____
Name Group# Address Telephone

Secondary Insured Member Employer_____

Name_____SS#_____Date of Birth_____

Secondary Dental Insurance Co._____
Name Group # Address Telephone

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weakened or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	No
Do you have a fever or above normal temperature?	☐	☐
Have you experienced shortness of breath or had trouble breathing?	☐	☐
Do you have a dry cough?	☐	☐
Do you have a runny nose?	☐	☐
Have you recently lost or had a reduction in your sense of smell?	☐	☐
Do you have a sore throat?	☐	☐
Have you been in contact with someone who has tested positive for COVID-19?	☐	☐
Have you tested positive for COVID-19?	☐	☐
Have you been tested for COVID-19 and are awaiting results?	☐	☐
Have you traveled outside of the US in the past 14 days? If so, where? _____	☐	☐

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Name: _____ Date: _____

TIMOTHY H. MIHLE, D.D.S, P.L.L.C

PATIENT'S MEDICAL HISTORY

PATIENT'S NAME: _____ DATE OF BIRTH: _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATIONS THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECIEVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	Y	N
1. ARE YOU IN GOOD HEALTH?	☐	☐
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR?	☐	☐
3. DATE OF YOUR LAST PHYSICAL EXAM _____		
4. PHYSICIANS NAME _____ ADDRESS _____ PHONE NO. _____		
5. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN?	☐	☐
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS? PLEASE EXPLAIN _____	☐	☐
7. ARE YOU TAKING ANY MEDICINE(S)? INCLUDING NON-PRESCRIPTION MEDICINE IF YES, WHAT MEDICINE(S) ARE YOU TAKING? _____	☐	☐
8. HAVE YOU HAD ANY ABNORMAL BLEEDING?	☐	☐
9. DO YOU BRUISE EASILY?	☐	☐
10 HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION?	☐	☐
11. HAVE YOU HAD A RECENT WEIGHT LOSS?	☐	☐
12. HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY CANCER MEDICATIONS CONTAINING BISPHOSPHONATES?	☐	☐
13. DO YOU / HAVE YOU USED CONTROLLED SUBSTANCES?	☐	☐
14. ARE YOU PRESENTLY ON A "PAIN MANAGEMENT" PROGRAM? WHO IS YOUR DOCTOR? _____	☐	☐
15. DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT?	☐	☐
16. ARE YOU TAKING BLOOD THINNERS?	☐	☐

WOMEN ONLY:

ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT?	☐	☐
ARE YOU NURSING?	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS?	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:	Y	N
LOCAL ANESTHETICS LIKE NOVOCAINE	☐	☐
*PENICILLIN OR OTHER ANTIBIOTICS	☐	☐
SULFA DRUGS	☐	☐
BARBITURATES, SEDATIVE OR SLEEPING PILLS	☐	☐
ASPIRIN	☐	☐
IODINE	☐	☐
ANY METALS (E.G. NICKEL, MERCURY, ETC.)	☐	☐
LATEX/RUBBER	☐	☐
OTHER (PLEASE LIST)	☐	☐
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:		
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	☐	☐
HEART DEFECT OR HEART MURMUR	☐	☐
HEART TROUBLE, HEART ATTACK OR ANGINA	☐	☐
CHEST PAIN	☐	☐
LUNG/BREATHING PROBLEMS	☐	☐
PACEMAKER	☐	☐
* HEART SURGERY	☐	☐
HIGH/LOW BLOOD PRESSURE	☐	☐
HEPATITIS, JAUNDICE OR LIVER DISEASE	☐	☐
STROKE	☐	☐
SINUS TROUBLE	☐	☐

	Y	N
ASTHMA OR HAY FEVER	☐	☐
HIVES OR SKIN RASH	☐	☐
FAINTING OR DIZZY SPELLS	☐	☐
DIABETES	☐	☐
AIDS OR HIV INFECTION	☐	☐
THYROID PROBLEMS	☐	☐
ALLERGIES	☐	☐
ARTHRITIS OR RHEUMATISM	☐	☐
JOINT REPLACEMENT OR IMPLANT DATE: _____	☐	☐
STOMACH ULCER	☐	☐
TUBERCULOSIS	☐	☐
CHEMOTHERAPY (CANCER, LEUKEMIA)	☐	☐
SEXUALLY TRANSMITTED DISEASE	☐	☐
EPILEPSY OR SEIZURES	☐	☐
TUMORS	☐	☐
MENTAL HEALTH CARE	☐	☐
BACK PROBLEMS	☐	☐
CHEMICAL DEPENDENCY	☐	☐
MITRAL VALVE PROLAPSE	☐	☐
CORTISONE TREATMENT	☐	☐
COLD SORE/FEVER BLISTERS	☐	☐
HYPOGLYCEMIA	☐	☐
KIDNEY DISEASE	☐	☐

HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT LISTED ON THE REVERSE SIDE OF THIS PAGE? ☐ **YES** ☐ **NO**

PLEASE DESCRIBE IN DETAIL _____

DO YOU WISH TO TALK TO THE DOCTOR PRIVATELY ABOUT ANY DENTAL PROBLEM ☐ **YES** ☐ **NO**

EMERGENCY CONTACT INFORMATION: NAME _____ TELEPHONE NO _____

INFORMED CONSENT

This is my consent to the endodontic procedures indicated and any other procedures necessary or advisable as a corollary to the planned endodontic therapy performed. I agree to the use of local anesthesia, sedation and/or analgesia, depending on the judgment of the endodontist. Complications of root canal therapy and anesthesia may include swelling, discomfort, infection, bleeding, sinus involvement, and numbness or tingling of the upper lip, gum or tongue, which rarely is permanent.

I understand root canal therapy is a procedure to retain a tooth that may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure so it cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery or even extraction.

I ALSO UNDERSTAND THAT THE ROOT CANAL THERAPY IS TO BE PERFORMED AT THIS OFFICE. THE PERMANENT (OUTSIDE) RESTORATION (FILLING, INLAY, CROWN, ETC.) WILL BE PERFORMED BY MY GENERAL DENTIST.

I understand that medications for pain and sedation may cause drowsiness which may be increased by the use of alcohol or other drugs. I will avoid operating any vehicle or hazardous devices while taking such medications. I further understand that certain medications may cause hives and intestinal problems and if any of these reactions occur, I am to call a doctor immediately. I understand that it is my responsiblity to report any changes in my medical history.

I ALSO ACKNOWLEDGE FULL RESPONSIBILITY FOR THE PAYMENT OF SUCH SERVICES AND AGREE TO PAY FOR THEM, IN FULL OR BEFORE COMPLETION, UNLESS SPECIFIC ARRANGEMENTS ARE MADE WITH THE OFFICE MANAGER IN ADVANCE.

ALL SIGNATURES MUST BE BY PARENT OR GUARDIAN IF PATIENT IS UNDER 18 YEARS OF AGE.

SIGNATURE _____ DATE _____

REVIEWED BY _____

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I understand that insurance is filed as a courtesy to me and is not a guarantee of payment. I also understand that it is not the policy of this office to enter into any dispute between myself and my insurance company. If my insurance company has not paid within 60 days, I will be billed and any balance remaining on my account will be my responsiblity.

SIGNED (PATIENT OR PARENT IF PATIENT IS A MINOR) _____
DATE _____

I HEREBY AUTHORIZE INSURANCE PAYMENT DIRECTLY TO: Timothy H. Mihle, D.D.S.

SIGNED (INSURED PERSON) _____ DATE _____

AS A COURTESY WE WILL SUBMIT INSURANCE CLAIMS FOR SERVICES RENDERED. ALL PAYMENTS/CO-PAYS ARE DUE AT THE TIME OF TREATMENT.

ACCEPTED FORMS OF PAYMENT:
CASH, MASTERCARD, VISA, DISCOVER & CARE CREDIT.

TIMOTHY H. MIHLE, D.D.S., P.L.L.C.
Endodontist
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(910) 343-3333 • (877) 671-6700
American Association of Endodontists
Specialist Member

ABOUT THE PRIVACY OF YOUR HEALTH INFORMATION

Our office has always protected the privacy of the health information of our patients. The entire staff has access to patient information to provide optimum care and obtain payment for treatment. Proper safeguards are in effect to ensure confidentiality of your records. A written office policy is in place and our staff is aware of the safeguards.

Regulations require that we make available for your review a copy of our office privacy policy if you so desire. Additionally, we are required to maintain on file your signature indicating we have informed you of your privacy policy. Your signature below is appreciated.

Signature_____

Date_____

BELOW IS AN APPROVED LIST OF PERSON(S) THAT MAY RECEIVE INFORMATION PERTAINGING TO MY TREATMENT AND/OR ACCOUNT

	NAME	BIRTHDATE	RELATION
1.			
2.			

By Law E-scripts only For Class II RX

Patient Name: _____

Date of Birth: _____

Pharmacy Name: _____

Phone Number:_____

Address / Zip: _____