truForm Usage Instructions

To use this form you must have Acrobat Reader 5 or greater installed.
Click here to download the current version of Adobe Acrobat Reader.

- Use the tab key to move from form field to form field.

-To enter in text, tab to (or click in) the area you wish to type in and begin typing.

-To check off choices on the form (yes/no type), click in the boxed or underlined area and an “x” or check mark should appear.

- To print out a copy of the form to retain for your records, click on the “Print Form” button toward the bottom of the last page.

- To send the completed form to our office, click “Submit Form” button toward the bottom of the last page.

If you experience difficulty submitting this form, please follow these directions:

1. Print the form.
2. Complete with black pen and bring the form to the office at the time of your appointment.
3. If you do not have a printer, you can fill out the form at the office prior to your appointment.

Please fill out the form as completely as possible If you have any questions, please contact your doctor.

For your protection:

This form is hosted on a secure server and can only be viewed by our office. Please feel confident in filling out this form, as all of your information will be kept safe at every step of the process. *This form follows HIPAA compliancy rules to ensure the security of your information.*

Welcome
Welcome
Welcome

WELCOME TO OUR PRACTICE

Date _____

PATIENT INFORMATION

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. _____ Last Name _____ Nickname _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____

Street _____ City _____ State _____ Zip _____

Home Tel. (_____) _____ Cell. (_____) _____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ Medical Doctor _____ Referred By _____

Driver's Lic.# _____ Nearest relative not living with you _____ Tel. (_____) _____

Employer _____ Bus. Tel. (_____) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

Who will be responsible for your account?

(If self, skip to next section)

❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ S.S.# _____ Birth Date _____ Age _____ Tel. (_____) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel. (_____) _____

Spouse or other guarantor information (*if different from above*)

Name _____ Relation _____ S.S.# _____ Tel. (_____) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel. (_____) _____

INSURANCE INFORMATION

Student: ❑ Full Time ❑ Part Time ❑ Not School Name/Address _____

❑ Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single _____

Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ Not Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY INSURANCE COMPANY

Insurance Type: ❑ **Dental** ❑ **Medical**

Employer _____

Bus. Address _____

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Tel. (_____) _____

Group # _____ **Group Name** _____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Birth Date _____

Street _____

City, State, Zip _____

Tel. (_____) _____ S.S. # _____

I.D. # _____

SECONDARY INSURANCE COMPANY

Insurance Type: ❑ **Dental** ❑ **Medical**

Employer _____

Bus. Address _____

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Tel. (_____) _____

Group # _____ **Group Name** _____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Birth Date _____

Street _____

City, State, Zip _____

Tel. (_____) _____ S.S. # _____

I.D. # _____

DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Consultation ❑ Emergency Are you in pain? ❑ Yes ❑ No, For How Long? _____

Please indicate any of the following problems by checking off the corresponding box:

❑ Discomfort, clicking, or popping in jaw
❑ Red, swollen, or bleeding gums
❑ A removable dental appliance
❑ Blisters / sores in or around the mouth
❑ Prolonged bleeding from an injury, extraction
❑ Recent infections or sore throat
❑ My teeth are sensitive to: ❑ Hot ❑ Cold ❑ Sweets ❑ Biting

❑ Lost / broken filling(s)
❑ Teeth grinding / clenching
❑ Ringing in ears
❑ Broken / chipped tooth
❑ Gum disease
❑ Toothache

❑ Stained teeth
❑ Locking jaw
❑ Bad breath
❑ Burning tongue/lips
❑ Grind / clench teeth
❑ Other:

❑ Difficulty closing jaw
❑ Difficulty opening jaw
❑ Loose / shifting teeth
❑ Food caught between teeth
❑ Swelling / lumps in mouth

Last Dental exam _____ Last Dental X-rays _____ Times a day you brush? _____ Times a week you floss? _____

What type of tooth bristles do you use? ❑ Soft ❑ Medium ❑ Hard How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

MEDICAL HISTORY

Are you in good health? ❑ Yes ❑ No Height _____ Weight _____ Are you under the care of a physician? ❑ Yes ❑ No

Have you had any illness, operation, or been hospitalized in the past five years? ❑ Yes ❑ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
❑	❑	Rheumatic fever	❑	❑	Asthma	❑	❑	Bleeding tendency	❑	❑	Low Blood Sugar
❑	❑	Mitral valve prolapse	❑	❑	Hay fever / Sinus problems	❑	❑	Jaundice / Liver Disease	❑	❑	Kidney trouble
❑	❑	Heart murmur	❑	❑	Snoring / Sleep apnea	❑	❑	Hepatitis	❑	❑	Are you on dialysis
❑	❑	High blood pressure	❑	❑	Respiratory Problems	❑	❑	HIV / AIDS	❑	❑	Arthritis / Joint disease
❑	❑	Low blood pressure	❑	❑	Tuberculosis	❑	❑	Infectious mononucleosis	❑	❑	Stomach ulcers
❑	❑	Chest pain / Angina	❑	❑	Emphysema	❑	❑	Gallbladder trouble	❑	❑	Contagious diseases
❑	❑	Heart attack(s)	❑	❑	Do you smoke	❑	❑	Fainting spells	❑	❑	Delay in healing
❑	❑	Irregular heart beat	❑	❑	Do you use chewing tobacco	❑	❑	Convulsions / Epilepsy	❑	❑	Anemia
❑	❑	Cardiac pacemaker	❑	❑	Blood transfusion	❑	❑	Stroke	❑	❑	Tumor or growth
❑	❑	Heart surgery	❑	❑	Blood disorder	❑	❑	Thyroid trouble	❑	❑	Radiation / Chemotherapy
❑	❑	Bronchitis / Chronic cough	❑	❑	Bruise easily	❑	❑	Diabetes	❑	❑	Are you on a diet
❑	❑	Chronic fatigue / Night sweat	❑	❑	A history of drug abuse	❑	❑	A history of alcohol abuse	❑	❑	Contact lenses
❑	❑	Mental health problems	❑	❑	Eye disease / Glaucoma	❑	❑	Sexually transmitted diseases	❑	❑	Immune system problems
❑	❑	Damaged heart valves	❑	❑	Abnormal bleeding	❑	❑	Swollen ankles	❑	❑	Malignant hyperthermia

MEDICATION AND ALLERGIES

Are you now taking:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Nerve pills	❑	❑	Pain killers (including aspirin)	❑	❑	Muscle relaxers	❑	❑	Stimulants
❑	❑	Have you ever taken diet pills	❑	❑	Tranquilizers	❑	❑	Insulin	❑	❑	Antidepressants
❑	❑	Blood Thinners (Coumadin, Aspirin, Advil)									

Please list any other medication you are taking (including natural, herbal, or homeopathic products):

Are you allergic to or had a reaction to:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Penicillin	❑	❑	Sulfa drugs	❑	❑	Local anesthetic (numbing med)	❑	❑	Sodium pentothal
❑	❑	Valium or other tranquilizers	❑	❑	Aspirin	❑	❑	Codeine or other narcotics	❑	❑	Latex
❑	❑	Soy	❑	❑	Eggs / Yolk	❑	❑	Sulfites	❑	❑	Amoxicillin

Please list any other medication or antibiotic you are allergic to:

Please list any allergies other than drug allergies:

1-4 below for women only: *(women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. consult your physician / gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? ❑ Yes ❑ No **2)** Expected delivery date: _____

3) Are you nursing? ❑ Yes ❑ No **4)** Are you taking birth control pills: ❑ Yes ❑ No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: *(Parent or Guardian if minor)* X **Reviewed by:** X **Date:** X

FEES AND PAYMENTS

We make every effort to keep down the cost of your oral surgical care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X

Print Form Submit Form

Consent Form For Endodontic (Root Canal) Treatment

Patient name:

I understand Dr.Binns is a general dentist who limits his practice to root canal treatment. I am satisfied with his qualifications and do not desire treatment by an endodontist .

_____
Patient initials

Root canal treatment is performed to save a tooth that might otherwise need to be removed. Root canal treatment is successful most of the time, but this cannot be guaranteed. At times a tooth that has had root canal therapy will require other additional treatments to save the tooth such as surgery to remove infection around the root tip, surgery to increase the length of a badly broken down tooth, filling or post and crown. All recommended treatments must be completed to insure the best chance of success. Failure to do so will ultimately result in failure and probable loss of the tooth. I understand the above explanation and have had all of my questions answered :

_____
patient initials

There are certain risks associated with these treatments. Complications may arise from use of dental instruments, drugs and anesthetics (novacaine, lidocaine,etc). The most common complications that can arise with root canal treatment are: Swelling, sensitivity, pain, bleeding, infection, delayed healing, reactions to shots or prescribed medications which include dizziness, drowsiness, nausea, vomiting, rash or other allergic reactions. Nerve damage resulting in prolonged or permanent tingling or numbness in the lip, tongue, lip, cheek, gum, or teeth. Changes in the way your teeth fit together resulting in loosening of teeth, jaw muscle cramps, joint difficulties, pain in the teeth, ear, neck , and head. Dental instrument failures and clinical misadventures that result in damage to existing dental work on the tooth and adjacent teeth, file and other instrument breakage, chemical burns and severe tissue reactions, sinus perforation, all of which can result in swelling, pain, infection, the need for additional treatment, and /or failure and tooth loss. The most severe infections and reactions to chemicals and medications can be life threatening resulting in hospitalization. These most severe complications are possible, but rare.
I understand the above explanation and have had all my questions answered:

_____
patient initials

There are other treatment choices available including, no treatment or removing the tooth. Risks of these choices include but are not limited to pain, infection, swelling, tooth loss, and infection to other areas of the body. I realize that in spite of the possible complications and risks, the recommended treatment is desired by me. I acknowledge that no guarantees have been made to me concerning the results of this treatment. I have had the opportunity to ask questions and receive answers and responsive explanations for all questions about my medical condition, contemplated and alternative treatments, and the risks and potential complications of the contemplated and alternative treatments, prior to signing this form.

_____
patient initials

I hereby authorize Michael J. Binns DDS and staff to perform the recommended and necessary treatment for me. I also authorize the use of the radiographs, photographs, or videotapes of my case for use in presentations or publications by the doctor. I also give permission for Dr. Binns, all doctors, & pharmacists to discuss my complete drug & medical history and understand Dr. Binns will not provide narcotic prescriptions if abuse is suspected.

_____ _____
Patient or Guardian Signature Date

_____ _____
Dentist's signature Date

_____ _____
Witness's signature Date

Recommendations Following Root Canal Treatment

1. **Limit your diet to soft foods or liquid until numbness wears off to keep from hurting the anesthetized tissues in your mouth. Feeling normally returns within 2 hours after treatment.**

2. **Your tooth will feel sore and bruised once the numbness wears off. Treat it the way you would a sprained ankle – stay off of it for a few days, apply a cold compress to face over the area of treatment. DO NOT APPLY HEAT. Heat will make the swelling and pain worse.**

3. **Anti inflammation medicine such as Advil is most effective. For pain not controlled by Advil alone, take 2 Advil AND 2 Tylenol tablets every 4 hours. This combination provides the same amount of pain relief as one codeine tablet, but without the side effects. Do not exceed the recommended dosage.**

4. **After 2-3 days your tooth may shift position so that you may notice increased discomfort when biting. This will normally improve on it's own over the next couple of days. We will be happy to adjust the bite for you if needed.**

5. **Dr. Binns after hours telephone number is770-314-0710. If you notice swelling or have excessive pain, please call him immediately to obtain a prescription.**

Please schedule an appointment with your regular dentist to have your tooth permanently restored as he/she recommends. Not doing so will lead to tooth breakage or re infection, causing root canal failure and possible loss of the tooth.

It was our pleasure to serve you. Thank you for selecting our office!