Irene C. Chang, D.D.S., M.S., Inc
Practice Limited to Endodontics

Name: Mr./Mrs./Ms./Dr. (please circle) ____
First Middle Last
I prefer to be called: ___________________ Sex: Male/Female (circle) Birth date: _____________ Age: _________

Home Address: ____
Street Apt # City State Zip
Home phone: ( )_______________ Work phone : ( )__________________ Cellular phone: ( ) ____________________
Social Security # __________________ Drivers License # __________________ E-mail address: ______________________

Referring Dentist's Name: ___________________________________ Referring Dentist's Telephone: ( ) _________________

Your Employer: ____ Occupation:_____________________________

Employer's Address: ____
Street Suite # City State Zip

Do you have dental insurance: YES [ ] NO [ ] (please check)

Policyholder's name: _______________________________________ Social Security #: _________________________
policyholder's birthday: _________________ Group #: __________________________________

Name & address of dental insurance carrier: ____

____
Street Suite # City State Zip Telephone

Spouse: ____
First Middle Last
Spouse's birth date: _________________ Social Sec. #: __________________ Spouse's work phone: ( ) _______________

Spouse's employer: ______________________________________ Occupation: ___________________________

Address of employer: ____
Street City State Zip

Spouse's insurance company: _______________________________ Group #: __________________________

Address: ____
Street Suite # City State Zip Telephone

In Case of Emergency—Name of Nearest Relative Not Living With You: _________________________________

Address: ____ **PHONE:** ( ) _________________

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INFORMED CONSENT

All of the information on the front and backsides of this form is true and correct to the best of my knowledge. I grant for my physician or dentist to be contacted for additional information. I further authorize the taking of radiographs, photographs or other diagnostic measures appropriate for a thorough evaluation. Authorization is also given for dental treatment to be rendered by the dentist and office staff.

I understand that Root Canal (endodontic) treatment is a procedure to retain a tooth, which might otherwise require extraction. Although Root Canal therapy has a very high degree of clinical success, it is still a biological procedure. No guarantee or assurance has been given that the proposed treatment will be curative and/ or successful to my complete satisfaction. Occasionally, a tooth, which has had Root Canal therapy, may require retreatment, surgery, or even extraction. I understand my inherent options of having no treatment at all, extracting the affected tooth, or attempting Root Canal therapy in order to save my tooth; and I understand the risks and benefits of each option.

I am aware that only the Root Canal treatment/surgery will be performed at this office. The permanent restoration (filling, crown, etc.) will be done by my regular dentist. In addition, I acknowledge full responsibility for the payment for those services, which are performed in this office. ***I am aware that the fees are due in full at or before completion, and that if I have dental insurance, a one –third deposit is required.***

MY ACCOUNT BALANCE WILL BE PAID BY: CASH [ ] CHECK [ ] CREDIT CARD [ ]

____________________________________ ___________________
Signature of Adult Patient, Parent, or Guardian Date

*****PLEASE COMPLETE REVERSE SIDE*****