ENDODONTIC
SPECIALTY GROUP, P.C.

Patient Name: ____ Preference: HE / SHE / THEY

First Middle Initial Last

Preferred Name: _____________________ DOB: __________________ SSN___________________

Parent/Guardians Name (if a minor): _____________________________________ DOB: _____________

First Last middle Initial

Patient Mailing Address: ____APT#_________

City___________________________________ State_______________ ZIP________________

Phone #1 ( )_________________________ Phone #2 ( )______________________________

Email Address: ____

Patient Employer: ___________________________________Occupation: ______________________

Spouses Name: ____________________________________Date of Birth: ______________________

First Middle initial Last

Method of Payment (circle one): Ins. Co-Payment Debit/Credit Cash/Check

DENTAL INSURANCE INFORMATION

Policy Holder Name: ____ DOB: _______________

Employer: __________________________ Relationship to Policy Holder: ______________________

Subscriber/Member ID#: ________________________________Group#: _______________________

Insurance Company Name: ____

SECONDARY INSURANCE (if applicable)

Policy Holder Name: ____ DOB: ________________

Employer: __________________________ Relationship to Policy Holder: _____________________

Subscriber/Member ID#: ________________________________Group#: _______________________

Insurance Company Name: ____

MEDICAL HISTORY

Yes	NO	
O	**O**	Do you have obstructive sleep apnea (OSA)?
		IF YOU HAVE NOT BEEN DIAGNOSED WITH OSA:
Yes	**NO**	
O	O	Snoring: Do you snore loudly?
O	O	Tiredness: Do you often feel tired, fatigued, sleepy during normal waking hours?
O	O	Observed breathing: Has anyone observed you stop breathing?
O	O	Blood Pressure: Do you have or are you being treated for high blood pressure?
O	O	BMI > 35? Height: ______ Weight: _____
O	O	Age > 50 years old
O	O	Neck circumference > 15.75 inches (40cm)?
O	O	History of cracking teeth?
M	F	Gender: Male or female (circle)

Reason for visit today: (circle ALL that apply)

AREA: Upper Front Right Left
Lower Front Right Left

SENSITIVE TO? Hot Cold Air Bite Pressures

FEELS LIKE? Sharp Zing Throbs Dull ache
(lingers or goes away right away?)

DISCOMFORT? Constantly? comes and goes? Spontaneous?
Intermittent? Provoked?

Taking medication for the tooth? If so what?
____

Dental treatment history:

YES	NO	
O	O	Have you had a root canal before? If you have had a root canal, how was your experience? (please circle one) Good OK Bad

General Health:

Yes	NO	
O	O	Are you under the care of a physician?
		-> If yes, what condition are you being treated for? ____________________
		-> Physicians name and contact information? ____________________
		-> Please list any serious illness or operation? ____________________
O	O	Have you been hospitalized within the last five years?
		-> If yes, please explain. ____________________

FEMALE PATIENTS: Are you pregnant? YES or NO If pregnant, due date: ____/____/____ Nursing? YES or NO

Are you allergic to any of the following? (please mark yes or no)

YES	NO	
O	O	Local Anesthetic
O	O	Penicillin or another Antibiotic
O	O	Barbiturates, Tranquilizers, Sleeping pills
O	O	Aspirin, Tylenol, Advil
O	O	Codeine or similar Narcotic
O	O	Latex
O	O	Other________________________

Have you EVER taken any of the following medications? (please mark yes or no)

YES	NO	
O	O	Fosamax
O	O	Didronel
O	O	Aredia
O	O	Boniva
O	O	Zometa
O	O	Skelid
O	O	Actonel
O	O	Bisphosphonate

List ALL medications you are currently taking?

1.______________________

2.______________________

3.______________________

4.______________________

or provide a list of medication to scan please.

Medical Conditions

YES	NO		YES	NO		YES	NO	
O	O	Heart Trouble (heart attack or angina?)	O	O	Hyperthyroid or Hypothyroid condition	O	O	Pacemaker
			O	O	Artificial joint or heart valves	O	O	Asthma, Sinusitis, hay fever
O	O	High or Low blood pressure	O	O	Kidney or bladder trouble	O	O	Respiratory condition
O	O	HIV / Immune suppression	O	O	Osteoporosis	O	O	Diabetes: Type I or II, A1C: ______
O	O	Rheumatic fever/ murmur	O	O	Epilepsy, convulsions / seizures (circle)	O	O	Bleeding disorders
O	O	Stroke (date: _______)	O	O	Anemia	O	O	Psychiatric care
O	O	Cancer, if yes what type?	O	O	Tuberculosis	O	O	Hepatitis or liver disease

Signature____ **DATE**____________

OFFICE USE ONLY: BP: _________/________ P: _______

FINANCIAL AGREEMENT

ENDODONTIC SPECIALTY GROUP, PC.

We share your concerns regarding the increasing cost of health care. We believe that you, our patients, deserve the best possible care we can provide at a reasonable cost. With this in mind, we would like to share some information with you about our financial policy. We want you to feel comfortable with us regarding your financial and insurance matters and thereby prevent any misunderstandings. We hope you will consult with us if you have any questions regarding our service and/or fees.

NEW PATIENTS: Patients without insurance are required to pay the charges at the time of service with the insurance information you have provided to out practice. Patients with insurance: we will forward your claim to your insurance company as a courtesy to you. The estimated out of pocket, or the estimated amount that the insurance does not cover, will be due at the time of service.

Please note that many people are under the impression that if they have insurance, it is the insurance company that owes the doctor for his/her services. This is NOT the case. The insurance contract is between the patient and the insurance company; therefore, the patient is responsible for the bill regardless of the insurance coverage. We are more than happy to submit to your insurance company for you; however, it is the responsibility of the patient (or insured) to provide our office with the correct insurance company name, address, telephone number, appropriate subscriber identification number(s), and the patient's and insured's birth dates.

Many insurance plans state that you will be covered "up to 50%, 80% or 100%. In spite of this statement, we have found in actuality that many plans may cover less than that depending upon their established "usual and customary" fees. Insurance companies use the term "usual and customary" when setting fee limitations on services. The benefits paid by your plan are largely determined by how much your employer or union paid for the plan. Please be aware that some insurance companies will pay for a claim percentage based on *their* "usual and customary", not our actual charges. If we are in "your network", also be aware that benefits shown do not guarantee coverage. We don't always see your previous pending claims, if any, and/or any additional co-pays that might be due in addition to our quotes to you on the estimates. We are happy to evaluate you if concerned and request a pre-authorization; however, this usually requires approximately three weeks to be processed by the insurance company.

PATIENTS WITHOUT INSURANCE: Charges are required to be paid in full at the time of service. An estimate will be given to you at your consultation/examination appointment or when the appointment is scheduled.

MEDICARE: None of the doctors in this office are Medicare providers, therefore our office is unable to bill Medicare for any services.

CREDIT CARDS: Visa, MasterCard, Discover and Care Credit may be used for payment on your account.

PARENTAL RESPONSIBILTY: Agreements between parents accepting or denying financial responsibility for dental/medical charges are not recognized by this office. We consider the guardian (custodial) parent to be responsible of services. Young adults (age 18 and older) are legally responsible for their accounts unless a parent accompanies them to the initial appointment and signs a financial agreement. This is the case regardless of insurance benefits for which they still may be eligible.

RETURNED CHECKS: Dishonored checks will be collected electronically. A fee of $25.00 will be charged for the check recovery as well additional bank fees.

ACCOUNT BALANCES: The balance on all accounts is due in full in 60 days regardless of insurance or anticipated payment from other sources. In the event that payment for endodontic services is not made within 60 days of receipt of the services, a finance charge of 1 ½ % per month, will be added to the account (18% per annum).

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be directly to the doctor. I am ultimately financially responsible for any balance due. If it becomes necessary to effect collections of any amount owed, I agree to pay for all costs and expenses, including reasonable attorney fees. I also authorize the doctor to release any information required for this claim.

SIGNATURE____**DATE**__________________

CONSENT and INFORMATION FORM

Regular Health History, Endodontic (Root Canal) Therapy, Premedication, Local Anesthetic and Medication.

It is the belief of this office that you should be informed about your treatment (therapy) and that you should give your consent before starting that treatment. Whether it be a consultation regarding your potential treatment or past treatment. The purpose of this form is to inform you of the *possible* risks involved with endodontic (root canal) treatment, and your alternatives.

Root canal treatment is done in order to retain a tooth (or teeth) which otherwise would need to be removed. Related dental surgery is done when needed.

Risks of treatment are of two kinds: those risks involved in general dental procedures, and those specific to endodontic treatment.

RISKS OF DENTAL PROCEDURES IN GENERAL: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections. These include pain, infection, swelling, bleeding, sensitivity, numbness, and tingling sensation to the lip, tongue, chin, gums, cheeks and teeth, reaction to injections, change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth and restorations in teeth, injury to other tissues, referred pain to the ear, neck and head, nausea, vomiting, allergic reactions, itching, bruises, delayed healing, sinus complications, and need for further surgery or extraction. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY: These risks include instruments separated within the root canals, perforations (extra openings) of the crown or root of the tooth, damage to bridges, existing filling, crowns or porcelain veneers, loss of tooth structure in gaining access to canals, and cracked teeth. During treatment complications maybe discovered which make treatment impossible, or which may require dental surgery. These complications may include: blocked canals due to fillings, prior treatment, natural calcification, broken instruments, curved roots, periodontal disease (gum disease/pyorrhea), splits or fractures of the teeth.

THE OTHER TREATMENT CHOICES: This may include *no* treatment, waiting for more definite development of symptoms, and/or having the tooth removed. Risks involved in these choices might include pain, swelling, infection, loss of tooth, infection to other areas. Treatment will be done in a manner to minimize or avoid risks.

I understand that upon my request I may receive a copy of this form. **I also understand that upon completion of root canal therapy in this office I will be directed to return to my general family dentist for permanent restoration such as crown, jacket, onlay or filling.** I, the undersigned, being the patient (parent or guardian of above minor patient) consent to the performing of the procedures decided upon or advisable in the opinion of the doctor.

Root canal treatment is an attempt to retain a tooth which would otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had a root canal may require re- treatment, surgery or even extraction.

PATIENT/PARENT SIGNATURE____ DATE ________________

HIPPA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The terms of this notice may change, if so, you will be notified at your next visit to update your signature and date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of you protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Please circle yes or no for the following questions:

1. May we phone, email, or send a text to you to confirm appointments? **YES** **NO**
2. May we leave a message on your answering machine at home or on your cell phone? **YES** **NO**
3. May we discuss your medical condition with any member of your family? **YES** **NO**
   - If YES, please name the members allowed below:

____

____

This consent was signed by: ____

(PRINT NAME PLEASE)

Signature: ____ DATE: ___________