WELCOME to ENDOART

Patient Information (Confidential)

Today's Date _____ Referring Dentist_____

Patient Name_____

Check Appropriate Box: ❒ Single ❒ Married ❒ Widowed ❒ Minor

SSN_____Birthdate_____

Mailing Address_____

City_____State_____Zip_____

Home Phone_____Cell_____

Email address_____

Preferred Pharmacy Name_____Phone _____

Pharmacy Address _____

Emergency Contact Name_____Phone_____

Dental Insurance Info

As a courtesy to our patients, we will call your insurance company to verify eligibility/benefits. However, this is not a guarantee of any insurance payment.
If we are unable to verify eligibility/benefits OR you are unable to provide your dental insurance information below, payment in full is required for all services. You will be reimbursed by your insurance company after providing current insurance information.

Dental Insurance Company Name_____PHONE_____

Subscriber Name_____Subscriber Employer_____

Subscriber SSN_____Subscriber Birthdate_____

Subscriber Member ID #_____ Subscriber Group #_____

Do you have Secondary Dental Insurance?

Sec Dental Insurance Company Name_____Phone_____

Sec Subscriber Name_____Sec Subscriber Employer_____

Sec Subscriber SSN_____Sec Subscriber Birthdate_____

Sec Subscriber Member ID #_____ Sec Subscriber Group #_____

About Root Canal Therapy

Root canal treatment is an attempt to retain a natural tooth that 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.

Patient Medical History

Physician_____Office Phone_____Date of Last Exam_____

1. Are you under medical treatment now? **No** **Yes…explain briefly**_____
2. Have you ever been hospitalized for a heart attack or stroke within the last year? **No** **Yes…**Date of hospitalization:_____
3. Have you ever regularly taken antibiotics prior to dental work **BECAUSE OF** cardiac transplants, mitral valve prolapse, artificial heart valves, SBE, heart murmur, Rheumatic Fever, kidney dialysis, or joint replacement? **No** **Yes…**What did you take?_____
4. Are you taking any ASPIRIN or BLOOD-THINNING medications? **No** **Yes…**Blood-thinning medication name:_____
5. Are you currently taking/have you ever taken biphosphonate medications such as Actonel/Fosamax/Zometa? **No** **Yes…**Name:_____
6. Are you taking any medication(s) including non-prescription medicine? **No** **Yes….If yes**, please list medication names and dosages:

MEDICATION NAME	Dosage	MEDICATION NAME	Dosage
_____	_____	_____	_____
_____	_____	_____	_____

7. **ALLERGIC REACTIONS:** Have you ever had any **ALLERGIC or ADVERSE REACTIONS** to the following:

Anesthetics (ie Lidocaine)	Y	N	Codeine	Y	N	Penicillin	Y	N	Sulfa drugs	Y	N
Aspirin	Y	N	Latex Rubber	Y	N	Other antibiotics	Y	N	Other:_____		

8. Do you have OR have you had any of the following?

Allergies/Hay Fever	Y	N	Frequ Tired/Easily Winded	Y	N	Mitral Valve Prolapse	Y	N
Anemia	Y	N	Glaucoma/Eye Disease	Y	N	Osteoporosis	Y	N
Angina/Chest Pain	Y	N	Heart Attack	Y	N	Pacemaker	Y	N
Anxiety/Nerv Disorders	Y	N	Heart Disease	Y	N	Prosthetic Heart Valve	Y	N
Arrhythmia	Y	N	Heart Murmur	Y	N	Respiratory Problems	Y	N
Asthma	Y	N	Hemophilia	Y	N	Rheumatic/Scarlet Fever	Y	N
Cancer	Y	N	Hepatitis/Jaundice	Y	N	Sinus Problems	Y	N
Chemo/Radiation Trmt	Y	N	High Blood Pressure	Y	N	Smoker	Y	N
Congestive Heart Failure	Y	N	High Cholesterol	Y	N	Stomach Ulcers/Colitis	Y	N
Delay in Healing	Y	N	HIV/AIDS Infection	Y	N	Stroke	Y	N
Diabetes	Y	N	Immune System Problems	Y	N	Swollen Ankles	Y	N
Emphysema	Y	N	Joint Replacement	Y	N	TMJ Syndrome	Y	N
Epilepsy/Convulsions	Y	N	Kidney Disease/Dialysis	Y	N	Tuberculosis	Y	N
Excessive Bleeding	Y	N	Leukemia	Y	N	Not Listed:_____		
Fainting/Dizziness	Y	N	Liver Disease	Y	N	_____		

9. **WOMEN ONLY**: Pregnant/May be pregnant? **Yes** **No** Nursing? **Yes** **No** Oral contraceptives? **Yes** **No**

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I authorize the Endodontist to release any information, including the diagnosis and records of any treatment or examination rendered to me or my dependent during the period of such endodontic care, to insurance companies, health practitioners, or other parties requested by me.

I consent to treatment. I authorize and request my insurance company to pay directly to the Endodontist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents, and I understand that a fee will be assessed if my account is referred to a collection agency.

I understand that after root canal therapy, my tooth will require an additional restoration (post/core build-up, crown) within 2-3 weeks. Should I neglect to return to my general dentist for the proper restoration, I understand there is an increased risk of failure of the root canal, fracture of the tooth, and/or premature loss of the tooth.

_____ _____ _____

Signature of patient (or parent/guardian if minor child) **Printed Name** **Date**

_____ _____

Doctor signature **Date**

ENDOART

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INFORMED CONSENT FOR NON-SURGICAL ENDODONTIC THERAPY (ROOT CANAL THERAPY)

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1. I consent to root canal therapy and the administration of local anesthetic as deemed necessary.

2. I understand the purpose of this treatment is to treat and possibly correct my diseased tooth.

3. I understand that extraction is an alternative treatment.

4. I understand that if my condition persists without treatment my present oral condition will probably worsen with time, and the risks to my health may include, but are not limited to: pain, swelling, infection, cyst formation, loss of supporting bone around my tooth/teeth, and premature loss of my tooth/teeth.

5. I understand that there are certain potential risks in any treatment, and that during root canal therapy the following risks include:

   - Postoperative discomfort lasting a few hours to several days for which medication will be prescribed if deemed necessary by the doctor.

   - Postoperative swelling in the vicinity of the treated tooth or facial swelling, either of which may persist for several days or longer.

   - Infection

   - Restrictive mouth opening, which lasts for several days but may last longer.

   - Failure rate of 5-10% for root canal and 10-20% for retreatment. If failure occurs, additional treatment will be required such as retreatment, apical surgery or extraction of the affected tooth. I also understand that there would be an additional cost for these procedures and I am responsible for those costs.

   - Breakage of root canal instruments in the tooth during treatment, which may be left in the treated root canal, require surgery for correction, or ultimately extraction.

   - Perforation of the root canal with instruments, which may require surgery for correction or extraction.

   - Fracture of porcelain on crown (cap) while preparing an opening in the crown for access to the root canals.

6. I understand that I am responsible to return to the office if the procedure is not finished in one visit.

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7. I understand that treatment may change during my endodontic procedure due to unanticipated circumstances i.e. calcified canals, obstructions not visible by x-rays, and/or additional canals. I also understand that there would be an additional cost for these procedures and I am responsible for those costs.

8. I understand that after root canal therapy, my tooth will require an additional restoration (post/core build-up/crown) within 2-3 weeks. Should I neglect to return for the proper restoration, there is an increased risk of failure of the root canal, fracture of the tooth, and/or premature loss of the tooth.

9. I understand that I am to return in several months for a re-evaluation visit so the doctor can monitor the root canal treatment for further treatment as may be necessary. Non-compliance may result in pain or a disabling infection.

DRUGS – MEDICATIONS - ANESTHESIA

10. I understand that antibiotics, analgesics, and other medications may cause adverse reactions, some of which are, but are not limited to, redness and swelling of tissues, pain, itching, vomiting, and dizziness.

11. I understand that medications, drugs, and anesthetics may cause drowsiness, and lack of coordination, which may be increased by the use of alcohol or other drugs. I have been advised not to consume alcohol, not to operate any vehicle or hazardous device while taking medications/ and or drugs, or until fully recovered from their effects (this includes a period of at least twenty four hours after my release from surgery)

12. I understand that occasionally, upon injection of a local anesthetic, I may have prolonged, persistent anesthesia, numbness, and/or irritation to the area of injection.

By signing below, I consent to treatment. I also state that I read and write English.

_____ _____

Patient Signature (or Parent/Guardian) **Date**

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NOTICE OF PRIVACY PRACTICES

This notice describes how dental/medical information about you may be used and disclosed and how you can get access to this information, therefore, please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program which requires that all medical/dental records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally are kept properly confidential. HIPAA gives you significant new rights to understand and control how your health information is used. We have prepared this explanation of how we are required to maintain the privacy of your health information, and how we may use and disclose your health information:

- Treatment means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include a dental exam.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example of this would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives, or other health related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you may exercise by presenting a written request to the privacy officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you notify us in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect, copy and amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of January 1, 2010, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. **We reserve the right to change the terms of our *Notice of Privacy Practices* and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of the revised *Notice of Privacy Practices* from the office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or with the Department of Health & Human Services Office for Civil Rights about violations of the provisions of this notice, or the policies and procedures of our office. We will not retaliate against you for filing a complaint.**

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my right to privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- *Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.*
- *Obtain payment from third-party payors for my health care service; and*
- *Conduct normal healthcare operations such as quality assessment and improvement activities.*

I have been informed of my provider's Notice of Privacy Practices containing a more complete description of the use and disclosures of my protected health information.

I have been given the right to review and receive a copy of such Notice of Privacy Practices. I may also contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that EndoArt restrict how my private information is used or disclosed in order to perform treatment, payment, or healthcare operations. I understand that EndoArt is not required to agree to my requested restrictions, but if EndoArt does agree, then they are bound to abide by such restrictions.

Patient Name **PRINTED**_____

Patient Signature_____

Relationship to patient **IF parent/guardian/spouse** _____ Date _____

ENDOART, PLLC

FINANCIAL POLICY

1. As a condition of treatment, financial arrangements must be made in advance. Based on the insurance information provided to our office, this is your estimated cost for the treatment listed. This amount is due and payable on the date the service is provided. Patients with dental insurance plans are required to pay their co-insurance, deductibles, or any non-covered services at the time of their visit.

2. As a courtesy, we will file your insurance claim on your behalf. We work very hard to maximize your insurance benefits as well as give you an accurate estimate of cost.
Determination of insurance benefits or requesting a pre-determination of benefits does not guarantee payment of claims. Sometimes insurance pays less than expected. Any portion of the bill not covered by your insurance plan is your obligation.

3. Upon completion of the root canal(s), it is your responsibility to return to your referring doctor to have a crown(s) placed on the tooth/teeth. If the restoration(s) is not completed within 2-3 weeks, your root canal(s) may fail, resulting in tooth loss.

4. FINANCIAL OPTIONS: **Please circle how you will be paying today……**

Cash VISA/MC/Amex/Discover CareCredit **must be pre-approved @ appt check-in (6mos no interest)**

5. If your insurance company does not pay within 60 days from the date of service, we will have to look to you for payment. Finance charges will be applied to balances over 60 days. After 90 days, unpaid accounts will be referred to the credit bureaus. Please contact your insurance company to review your benefits. You are responsible for all charges, regardless of insurance coverage.

6. DELINQUENT PAYMENTS
The following types of accounts will be referred to a collection agency:
A. Mail returned with no forwarding address.
B. Guarantors/patients who refuse to cooperate.
C. Guarantors/patients who do not make promised payments.
D. Guarantors/patients who do not respond to telephone or mail contacts.
NOTE: A $25 collection fee will be added to the delinquent balance if the account is sent to a collection agency.

7. INSUFFICIENT FUND CHECKS
If a check is returned due to insufficient funds, the payor/patient will immediately be referred to a collection agency without contact from this office. All NSF charges will be added to the payor/patient's balance in addition to a $25 collection fee. The NSF check will need to be replaced with cash or credit card payment.

8. OVERPAYMENTS/REFUNDS
These are issued after all insurance claims have been closed/settled.

I have read and understand the financial policies printed above and agree to these terms.

DATE_____SIGNATURE_____