

**Patient Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 First Middle Last

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ General Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse or Parent’s Name (if patient is a minor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insured’s Name & Relation to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policyholder’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Co: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID # or Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group# or Account #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID # or Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # or Account #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are completing this form for another person, what is your relationship to that person:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medical History Form**

**FIRST NAME: \_\_\_\_\_ LAST NAME:**

 **YES NO UKNOWN**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Do you have unhealed injuries or inflamed areas, growths, or sore spots in or around your mouth?
 |  |  |  |
| 1. Has there been any change in your general health within the past year? If yes, please explain:
 |  |  |  |
| 1. Are you under the care of a physician for a current problem? If yes, please explain:
 |  |  |  |
| 1. Have you been hospitalized within the past 5 years? If yes, please explain:
 |  |  |  |
| 1. Have you received therapy for alcoholism or drug addiction during the past 5 years?
 |  |  |  |
| 1. Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetics/antibiotics/medications? If yes, please explain:
 |  |  |  |
| 1. Is there any condition concerning your health that the doctor should be told?
 |  |  |  |
| 1. Do you wish to speak to the doctor privately about anything?
 |  |  |  |
| 1. Have you had abnormal bleeding with previous extractions, surgeries, or trauma?
 |  |  |  |
| 1. Have you ever required a blood transfusion?
 |  |  |  |
| 1. Have you ever had surgery and/or radiation for a tumor, growth, or other condition?

If yes, please explain: |  |  |  |
| 1. Have you ever tested positive for HIV infection or AIDS? If so, date diagnosed and the treating doctor:
 |  |  |  |
| 1. Are you required to take antibiotics prior to any dental treatment?
 |  |  |  |

1. **Have you had any of the following? If yes, please check the boxes below.**

|  |  |  |  |
| --- | --- | --- | --- |
| High blood pressure |  | Sinus trouble |  |
| Heart murmur or prolapsed valve |  | Thyroid problems |  |
| Joint prosthesis (hip, knee, etc.) |  | Diabetes |  |
| Rheumatic fever/rheumatic heart disease |  | Stomach ulcers, colitis |  |
| Congenital heart disease |  | Hepatitis, jaundice, liver disease |  |
| Cardiovascular disease |  | Kidney problems |  |
| Prosthetic heart valve |  | Psychiatric treatment |  |
| Blood disorder (e.g. anemia) |  | Fainting spells or seizures |  |
| Venereal disease |  | Epilepsy |  |
| Asthma |  | Cancer |  |
| Allergy to latex |  | Temporomandibular joint problems (TMJ) |  |
| Low blood pressure |  | Low blood sugar |  |
| Chest pain, angina |  | Dialysis |  |
| Swollen ankles, arthritis, or joint disease |  | Irregular heartbeat |  |
| Cardiac pacemaker |  | Contagious diseases |  |
| Heart surgery |  | Bronchitis, chronic cough |  |
| Delay in healing |  | Hay fever or sinus problems |  |
| Tuberculosis |  | Problems with the immune system |  |
| Emphysema |  | Difficult breathing or other lung trouble |  |
| X-ray treatment or chemotherapy |  | Chronic fatigue or night sweats |  |
| On a diet |  | History of drug abuse |  |
| History of alcohol abuse |  | Wear contact lenses |  |
| Eye disease |  | Bruise easily |  |
| Infectious mononucleosis |  | Gallbladder trouble |  |

  **YES NO UNKNOWN**

|  |  |  |  |
| --- | --- | --- | --- |
| 1. Are you taking any herbal medicine (i.e. St. John Wort)?
 |  |  |  |
| 1. Have you ever taken the “fen-phen” diet?
 |  |  |  |
| 1. Do you have any disease, condition, or problem not listed above? If yes, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| 1. Are you taking bisphosphonates now or have you in the past? (Fosamax)
 |  |  |  |
| 1. Are you taking any medications or drugs? If yes, please list them below:

 Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for Taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for Taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for Taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for Taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason for Taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Women only:**

Possibility of pregnancy: YES / NO Nursing: YES / NO

Estimated delivery date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Taking birth control pills: YES / NO

**NOTE:** Antibiotic (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of control.

**If this visit is related to an injury, fill out fields below:**🞎

|  |
| --- |
| 🞎 Accident Related 🞎 Work Related |
| Date of injury: |
| Insurance Company Handling Claim: |
| Claim Number: |
| Name of Attorney/Adjustor: |
| Attorney/Adjustor Telephone Number: |

**Physician’s Info: Emergency Contact Info:**

|  |  |
| --- | --- |
| Physician Name: | Name: |
| Physician Phone: | Home Phone: |
| Specialist Name: | Cell Phone: |
| Specialist Phone: | Work Phone: |

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Patient (or Responsible Party)



**Financial Policy**

The fee for root canal treatment is based upon the complexity of the tooth which is to be treated. All fees will be verbally quoted, prior to the start of treatment. Our office will charge for examinations and CBCT scans when performed.

**If dental insurance applies:** Most insurance companies do not cover 100% of the charges. Your copay is due at the time of service (the portion we **estimate** your insurance will not cover). Although this office files insurance claims as a service to the patient, the insurance contract is between the patient and the insurance company. All copays are an **estimate** based on the breakdown of benefits we receive from your insurance company. As we have no control over the insurance company's method of payment or amount of payment, **any difference of payment is entirely the responsibility of the patient**.

**Self-Pay Patients:** It is our office policy that the full fee for treatment is paid on the day of treatment. We accept cash checks, MasterCard, Visa or Discover. As an additional option we partner with Care Credit, a third-party financing company.

We realize that temporary financial problems may affect timely payments to your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, PLEASE do not hesitate to ask us. We are here to help.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Patient (or Responsible Party

**ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize and request my insurance company to pay directly to the Doctor the amount due on my claim for services rendered to me or my dependent.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Patient (or Responsible Party)



**HIPAA Notice of Privacy Practices**

**THIS NOTICE DESCRIBES HOW MEDICAL/DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND**

**HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

**Uses and Disclosures of Protected Health Information**

 Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s or dentist’s practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care for you. For example, your protected health information may be provided to a physician or dentist to whom you have been referred to ensure that the physician or dentist has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission or submission of a “pre-determination of benefits” to your insurance carrier may necessitate disclosure as well.

**Healthcare Operation:** We may use or disclose, as needed, your protected health information to support the business activities of your physician’s or dentist’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. We may also call you by name in the waiting room when your physician or dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your health information in the following situations without your authorization. These situations include: as Rights By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers’ Compensation: Inmates: Required Uses and Disclosures: Under the law, we must disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Patient (or Responsible Party)



**HIPPA Medical Release of Information**

**(optional)**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize the release of the following information including my diagnosis, records, treatment recommendations, and financial requirements as a patient of Root Dental Specialists to the following recipients:

[ ] Spouse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Parent \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This release of information will remain in effect until terminated in writing by patient.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Patient (or Responsible Party)



**CONSENT FOR ENDODONTIC EVALUATION & THERAPY**

Please review the following consent form. You will be required to sign this form prior to the initiation of treatment. Your signature does not commit you to any treatment.

I understand root canal therapy is a procedure that retains a tooth, which may otherwise require extraction. As a specialty practice, this office performs only endodontic therapy and associated surgery. Although root canal therapy has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth, which has had root canal therapy, may require retreatment, surgery, or even extraction. Following treatment, the tooth may be brittle and subject to fracture. **A restoration (filling), crown and/or post and core will be necessary to restore the tooth, and your general dentist will perform these procedures and it is the responsibility of the patient to schedule.** During endodontic treatment, there is the possibility of instrument separation within the root canals, perforations (extra openings), damage to bridges, existing fillings, crowns, or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals, and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when the tooth may not be amenable to endodontic treatment at all. Other treatment choices include no treatment, a waiting period for more definitive symptoms to develop, or tooth extraction. Risks involved in those choices might include, but are not limited to, pain, infection, swelling, loss of teeth, and infection to other areas.

Occasionally, medication will be prescribed by our office. Medications prescribed for discomfort and/or sedation may cause drowsiness, which can be increased by using alcohol or other drugs. We advise that you do not operate a motor vehicle or any hazardous device while taking such medications. In addition, certain medications may cause allergic reactions, such as hives or intestinal discomfort. If any of these problems occur, call our office immediately. It is the patient's responsibility to report any changes in his/her medical history to our office.

**If you are unclear about the costs associated with your treatment or evaluation, please speak with a staff member.**

All my questions will be answered by the doctor, and I fully understand the above statements in this consent form.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Patient (or Responsible Party)

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**Consent Form for Dental X-rays and CBCT Scan**

Dental radiographs (x-rays) are essential, preventative, diagnostic tools that provide valuable information not visible during a regular dental exam. Dentists use this information to safely and accurately detect hidden dental abnormalities, infections and complete an accurate treatment plan. Without x-rays, problem areas may go undetected.

Our office uses a digital x-ray system for individual films, as well as a Cone Beam CT scan machine for cases that require a more detailed view of the area of concern. If you are asked to have a Cone Beam CT scan while in our office, please keep in mind the dental CT scan differs from a Medical CT scan. Cone Beam CT scans are performed while the patient is standing up and take less than 2 minutes to complete. If you are unable to stand for the scan, we can provide a stool for comfort.

Dental x-rays & CT scans both produce a low level of radiation and are considered safe. Dentists take necessary precautions to limit the patient's exposure to radiation when taking dental x-rays and CT scans. These precautions include using lead apron shields to protect the body and using modern, digital sensors that cut down the exposure time of each x-ray. **If you are pregnant, we would not want to expose you to such radiation unnecessarily. If you are or could be pregnant, please let us know immediately. We will discuss the options with you and your doctor.**

The need for dental x-rays depends on each patient's individual dental health needs. The doctor will recommend necessary x-rays based on the review of your medical and dental history, dental exam, signs, and symptoms.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Patient (or Responsible Party)