ROOT CANAL SPECIALISTS

Patient Information Form

Patient Last Name: _____ First: _____ M: _____

Birth Date: _____ Sex: M/F _____

Social Security _____ Marital Status: _____

Address: _____ City/State/Zip: _____

Cell phone: _____ alternate phone: _____

Email: _____

Employer _____

Guardian/Parents

Name: _____ Birth Date: _____

Cell phone: _____ Alternate phone: _____

Insurance Information

Insurance Subscriber name (Policy Holder): _____

Subscriber SS#: _____ DOB: _____

Insurance Co: _____ Address: _____

Insurance Tel: _____

In Case of Emergency (List a relative or local friend not living at same address)

Name: _____ Cell phone: _____

MEDICAL HISTORY

PATIENT NAME _____ **Birth Date** _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐Yes ☐No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ☐Yes ☐No If yes, please explain: _____
Have you ever had a serious head or neck injury? ☐Yes ☐No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ☐Yes ☐No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ☐Yes ☐No
Are you on a special diet? ☐Yes ☐No
Do you use tobacco? ☐Yes ☐No
Do you use controlled substances? ☐Yes ☐No
Do you need to pre-medicate? ☐Yes ☐No If yes, please explain: _____

Women: Are you Pregnant/Trying to get pregnant? ☐ Yes ☐No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?

☐ Latex ☐ Penicillin ☐ Codeine ☐ Aspirin ☐ Local Anesthetics ☐ Metal ☐ Acrylic

Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐Yes ☐No	Cortisone Medicine	☐Yes ☐No	Hemophilia	☐Yes ☐No	Renal Dialysis	☐Yes ☐No
Alzheimer's Disease	☐Yes ☐No	Diabetes	☐Yes ☐No	Hepatitis A	☐Yes ☐No	Rheumatic Fever	☐Yes ☐No
Anaphylaxis	☐Yes ☐No	Drug Addiction	☐Yes ☐No	Hepatitis B or C	☐Yes ☐No	Rheumatism	☐Yes ☐No
Anemia	☐Yes ☐No	Easily Winded	☐Yes ☐No	Herpes	☐Yes ☐No	Scarlet Fever	☐Yes ☐No
Angina	☐Yes ☐No	Emphysema	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Shingles	☐Yes ☐No
Arthritis/Gout	☐Yes ☐No	Epilepsy or Seizures	☐Yes ☐No	Hives or Rash	☐Yes ☐No	Sickle Cell Disease	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	Excessive Bleeding	☐Yes ☐No	Hypoglycemia	☐Yes ☐No	Sinus Trouble	☐Yes ☐No
Artificial Joint	☐Yes ☐No	Excessive Thirst	☐Yes ☐No	Irregular Heartbeat	☐Yes ☐No	Spina Bifida	☐Yes ☐No
Asthma	☐Yes ☐No	Fainting Spells/Dizziness	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Stomach/Intestinal Disease	☐Yes ☐No
Blood Disease	☐Yes ☐No	Frequent Cough	☐Yes ☐No	Leukemia	☐Yes ☐No	Stroke	☐Yes ☐No
Blood Transfusion	☐Yes ☐No	Frequent Diarrhea	☐Yes ☐No	Liver Disease	☐Yes ☐No	Swelling of Limbs	☐Yes ☐No
Breathing Problem	☐Yes ☐No	Frequent Headaches	☐Yes ☐No	Low Blood Pressure	☐Yes ☐No	Thyroid Disease	☐Yes ☐No
Bruise Easily	☐Yes ☐No	Genital Herpes	☐Yes ☐No	Lung Disease	☐Yes ☐No	Tonsilitis	☐Yes ☐No
Cancer	☐Yes ☐No	Glaucoma	☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Chemotherapy	☐Yes ☐No	Hay Fever	☐Yes ☐No	Pain in Jaw Joints	☐Yes ☐No	Tumors or Growths	☐Yes ☐No
Chest Pains	☐Yes ☐No	Heart Attack/Failure	☐Yes ☐No	Parathyroid Disease	☐Yes ☐No	Ulcers	☐Yes ☐No
Cold Sores/Fever Blisters	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Psychiatric Care	☐Yes ☐No	Venereal Disease	☐Yes ☐No
Congenital Heart Disorder	☐Yes ☐No	Heart Pace Maker	☐Yes ☐No	Radiation Treatments	☐Yes ☐No	Yellow Jaundice	☐Yes ☐No
Convulsions	☐Yes ☐No	Heart Trouble/Disease	☐Yes ☐No	Recent Weight Loss	☐Yes ☐No		

Have you ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ **DATE** _____

SIGNATURE OF DOCTOR _____ **DATE** _____

Financial agreement and insurance benefits assignment

Patient Name: _____ Date:_____

I authorize my insurance carrier to issue the dental benefits of my plan directly to the dental office. I also authorize release of information necessary to process dental insurance. **I understand that regardless of insurance, I am responsible for the total amount for the treatment done.**

I understand that, signing this form does not imply in any way that my insurance company will cover any of the services rendered by *Viscount Endodontic Group, PLLC*'s staff. Our office or its employees cannot guarantee the accuracy of any information given by my insurance company regarding my benefits. Based on such information given by my insurance company, *Viscount Endodontic Group, PLLC* staff will compute an estimate of payment due, as described in the "treatment plan" document. Payment is due on the day the services are rendered (referred to as Service Date from here onwards).

I understand that our office's staff may file for payments with my insurance company. If my insurance company does not pay EP Root Canal Specialists for all the services rendered, in full, within 90 days from the Service Date, I am responsible for the remainder of the amount due immediately.

I understand that any amount that is not paid within 90 days from the Service Date is considered "Past Due". A finance charge of 1.5% per month will be applied on all of the "Past Due" amounts from the Service Date onwards until all such "Past Due" amounts are paid in full.

I understand that there is a "returned check fee" on any checks written to the extent allowed by law plus a check handling fee of $35 per returned check incidence. Solely at the discretion of our office, the check may be turned over to the District Attorney's office for legal action. If the account is "Past Due" finance charges of 1.5% per month will be applied on such fees as well.

I understand that after reasonable attempts at collecting payments for services rendered and any finance charges and other charges to the account, *Viscount Endodontic Group, PLLC* may send the account for collection to a collection agency or small claims court, solely at the discretion of the office. If the collection agency or small claims court is unable to collect full payment within a reasonable duration, the account may be reported as delinquent to Credit Reporting Agencies.

_____ _____

Patient/Guardian Signature Date:

Witness_____

HIPAA & Your Privacy Rights

We strongly believe in doing everything we possibly can to safeguard the privacy and security of your health information and records. As a result, we have made some change in our office management procedures to make sure we follow the health information Portability and Accountability Act (HIPAA). Passed into law in 1996, HIPAA sets federal standards for the privacy and security of patient information for all healthcare providers, plans, insurance companies and anyone they do business with. HIPAA gives you additional rights regarding control and use of your health information, meaning you have more access and control than ever. Please take a few minutes to review these new rights. We are happy to answer any question you may have.

Control over Your Health Information

All health care providers (and health plans) are now required to give you a written explanation of how they use and disclose your personal health information before they can treat you. This way, you can decide if a provider is doing everything they should to protect your privacy before you choose them as your caregiver. We must by law, post a Notice of Privacy Practices, which outlines how we secure the privacy of patient information, in a place where you can easily see it. We must get your signature for non-routine users and disclosures of your information. A non-routine use is any situation not directly related to treatment, payment or operations. For example, if your child is going to summer camp and the camp needs a medical history, you will be asked to authorize us to release it before we can send the information. You have the right to say no, and you don't have to tell anyone why. Authorizations of non-routine information are one-time –only, case by case, for the use defined by you.

Access to Your Health Information

You can get copies of your medical records simply by asking for them. Healthcare providers are required to get your a copy of your records within 60 days of your request. There may be a cost for this service. Providers also must give you a history of non-routine disclosures if you ask for it. All you need to do is ask for the record and it is provided to you – no justification is needed. You can also amend your medical records. You cannot change the existing record, but you can add notes or comment on any procedures, treatments, payments or operations. The provider then has the right to respond to your amendment. This way, you can be sure your records reflect your side of the story about treatment and payment issues.

Patient Recourse if Privacy Protections Are Violated

Every healthcare provider must also inform you of grievance procedures. If your privacy is violated, report the incident to our Privacy Officer immediately. You also have the right to report any violation to the Department of Health and Human Services, Office of Civil Rights. 200 Independence Avenue, SW, Washington, D.C. 20201. If you decide to file a grievance either with us or with the Department of Health and Human Services, we are not allowed to discriminate or retaliate against you in any way. Aside from these new rights to access and control of your medical information under HIPAA, there are also clear limits on all healthcare providers regarding how they disclose medical information. Here are some of the key aspects of these boundaries: Providers must ensure that health information is not used for non-health purposes. Health information (covered by the privacy rules) generally may not be used for purposes not related to health care – such as disclosures to employers to make personnel decisions, or to financial institutions – without your explicit authorization. There are clear, strong protections against using health information for marketing. The privacy rules set new definitions, restrictions and limits on the use of patient information for certain marketing purposes. Providers must get your specific authorization before sending you any materials other than those related to treatment. Use only the minimum amount of information necessary. In General, use or disclosures of information will be limited to the minimum necessary. This does not apply to disclosure of records for treatment purposes, because physicians, specialists and other providers may need access to the full record to provide quality care.

Exceptions

There are situations where healthcare providers may not have to follow these privacy rules. They include: emergency circumstances; identification of a body or the cause of death; public health needs; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security.

We understand your right to have your medical information kept confidential. Out compliance with the Health Information Portability and Accountability Act is one example of our advocacy and leadership on issues of patient's rights and privacy of information. We encourage you to ask questions and look forward to working together to improve the quality of your healthcare experience.

Patient/Guardian Signature **Print Name** **Date**

General Treatment Consent Form

Patient Name:_____

1. CONSENT FOR TREATMENT

I give permission to EP Root Canal Specialists and the office staff to treat any of my oral and dental related problems such as endodontic therapy, periodontal therapy and oral surgery. **(initials)**_____

2. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working other teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedure. I give my permission to the Dentist to make any/all changes and additions as necessary. **(Initials)**_____

3. DRUGS AND MEDICATIONS

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction) **(initials)**_____

4. NITROUS OXIDE

I understand that the administration of nitrous oxide (laughing gas) carry certain common hazards; risks and potential unpleasant side effects which are infrequent, but nonetheless occur. These Include, but are not limited to sweating, nausea, and vomiting. Please let the Dentist know if you experience these symptoms as the level of nitrous oxide can be adjusted. Recovery time is usually short, but may be prolonged, requiring you to remain in the office for some time. Although not usually required, it may be best to have a responsible adult accompany you to drive you home. You may have a light meal a few hours before the procedure.

If you are pregnant or think you are pregnant please let the Dentist know as Nitrous Oxide can cause premature birth.

(initials) _____

5. I understand that dentistry is not an exact science and that, therefore, reputable, practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment. **(initials)** _____

I, Dr. _____ have verbally explained the risks and complications of this treatment to the patient as well as presenting the alternative treatment plan.

Signature of Patient/Guardian _____ Date _____

Signature of Dentist _____ Date _____

Signature of Witness _____ Date _____

Endodontic Consent Form

Patient Name: _____

We would like for you to be informed about various procedures involved in your endodontic care. This information is not to alarm you, but to inform you of the risks, hazards, and benefits to help you make the best treatment decision for you.

1. **Root Canal Treatment** is a procedure to retain a tooth that would otherwise require extraction. The inside of the tooth contains tissue called the dental pulp, which is mostly made up of nerves and blood tissue. When the dental pulp becomes diseased, it must be removed. Under local anesthetic, a small hole is drilled into the center of the tooth. Then, the inside of the tooth is cleaned and disinfected with sterile files and irrigation. Finally, the canals are filled with gutta percha and sealer.
2. **Success Rate**: Root canal treatment typically has a very high success rate (greater than 90% success for routine cases). However, as root canal therapy is a biological procedure, no treatment outcomes can be guaranteed for any length of time.
3. There are some teeth that, unfortunately, do not respond root canal therapy. Despite our best efforts, a tooth may occasionally require re-treatment, surgery and/or extraction.
4. **Potential complications:** all complications are rare, but may occur during or after treatment. Possible complications include, but are not limited to: instrument separation (that cannot be removed), perforation, inability to negotiate a canal, anesthetic difficulties, split or fractured tooth, pain, swelling, infection, TMJ pain, limited opening, muscle soreness, adverse reaction to prescribed drugs/anesthetic/dental materials, and/or any other potential adverse reactions.
5. Every effort will be made to preserve existing restorations (e.g., crown, bridge, etc). Occasionally a restoration may be removed or damaged during treatment. We cannot be held responsible for repair or replacement of existing restorations.
6. Your tooth should be restored with a permanent restoration (i.e., crown) in a timely manner. Delays in having a tooth restored may result in lost fillings, re-infection, tooth fracture and/or loss of the tooth.
7. **Alternatives to root canal therapy:** are limited to endodontic retreatment, apical surgery, extraction, and/or no treatment. No treatment may result in an inoperable tooth, severe dental pain, swelling and/or emergency complications. Antibiotics alone <u>will not cure</u> a diseased dental pulp.

I have been given the opportunity to ask questions, and all of my questions pertaining to conditions, procedures, risks and benefits of treatment have been answered. I hereby authorize the recommended treatment under local anesthetic and perform any added procedures deemed necessary.

Root canal Therapy # _____ **Re-treatment #:**_____

Patient/Guardian Signature _____Date_____

Doctor Signature _____Date_____