Mt. Scott Endodontics, P.C.

PATIENT INFORMATION

Patient ______________________________ Birth Date: __________
First Middle Last

Home Address PO Box: ______________________________

Street: ______________________________

City: __________ State: __________ Zip Code: __________

Phone Numbers Home: __________ Business: __________

Cell: __________

Employment Patient employed by: ______________________________

Occupation: __________ Social Security No.: __________

Spouse's name or patient's parent (if minor): ______________________________

Spouse/Parent employed by: ______________________________

Occupation: __________ Business Phone: __________

If patient is a minor, who is legally and financially responsible? ______________________________

In case of emergency who should we contact? ______________________________

Phone: __________ Relationship: __________

Referring Dentist: ______________________________

INSURANCE INFORMATION

Name of Insurance Company: __________ Phone: __________

Insurance Address: ______________________________

Subscriber's Name: ______________________________

Subscriber's I.D. No.: __________ Birth Date: __________

Subscriber's Employer: ______________________________

Group and/or Policy No.: ______________________________

Is treatment covered by additional insurance coverage? ______________________________

Secondary Insurance Company: __________ Phone: __________

Insurance Address: ______________________________

Subscriber's Name: ______________________________

Subscriber's I.D. No.: __________ Birth Date: __________

Subscriber's Employer: ______________________________

Group and/or Policy No.: ______________________________

I UNDERSTAND THAT THE TOTAL PAYMENT OF THE DENTAL SERVICE IS MY RESPONSIBILITY AND NOT THAT OF THE INSURANCE COMPANY.

(OVER)

HEALTH HISTORY

1. Name of Physician ______________________ Phone: ______________
2. Date of last physical examination ______________________
3. Are you currently under the care of a physician for any medical problems? ❒ Yes ❒ No
   if so, please list ______________________
4. Have you ever had a serious illness or major operation? ❒ Yes ❒ No
   if so, please list ______________________
5. Are you taking any medications regularly? (Prescription or over the counter) ❒ Yes ❒ No
   if so, please list ______________________
6. Have you had an adverse reaction or allergy to any of the following:
   - Aspirin ❒ Yes ❒ No
   - Dental Anesthetics ❒ Yes ❒ No
   - Anti-inflammatory medications ❒ Yes ❒ No
   - Penicillin or other antibiotics ❒ Yes ❒ No
   - Codeine or other pain medications ❒ Yes ❒ No
   - Latex Materials ❒ Yes ❒ No
7. Are there any medications you cannot take? ❒ Yes ❒ No
   if so, please list ______________________
8. Have you ever had abnormal bleeding or difficulty with clotting after a wound? ❒ Yes ❒ No
9. Do you smoke? ❒ Yes ❒ No
10. Please fill in appropriate box if you have had any of the following?

❒ Alcoholism/Drug Dependency
❒ Artificial joints/Prosthetic Implants
❒ Bacterial Endocarditis
❒ Cancer
❒ Cardiovascular Disease
❒ Diabetes
❒ Emphysema
❒ Epilepsy
❒ Glaucoma
❒ Heart trouble of any kind
❒ Heart murmur
❒ Hepatitis/Jaundice
❒ High/low blood pressure

❒ HIV positive/Aids
❒ Kidney problems
❒ Mitral valve prolapse
❒ Organ transplant
❒ Prosthetic cardiac valves
❒ Prostate disorders
❒ Radiation therapy
❒ Rheumatic fever
❒ Seizures or convulsions
❒ Stroke
❒ Syncopy/Tendency to faint
❒ Tuberculosis
❒ Ulcers

11. Are you taking female hormones (oral contraceptives, etc.)? ❒ Yes ❒ No
12. Are you pregnant or nursing at the present time? ❒ Yes ❒ No

Signature: ______________________ Date: ______________

Mt. Scott Endodontics, P.C.

FINANCIAL AGREEMENT

By signing below I acknowledge my responsibility for payment for the services received at time of visit from Mt. Scott Endodontics in accordance with their regular fees and terms. My responsibility is not modified by whether any third party (insurance) pays for all, part or none of the charges. After estimated co-pay and insurance payment is made, any balance not paid is subject to a 1.5% finance charge after 30 days and is then considered delinquent. I also understand that I am responsible to pay reasonable attorney's fees and collection expenses incurred and expended in the event should my account be referred to an attorney or agency for collection.

Assignment: I authorize payment to be made directly to the dentist by my insurance company and I accept financial responsibility for all services not covered.

Patient/Parent Signature: ______________________ Date: ____________

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). 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 payers for my health care services.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses 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 understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office to obtain a current copy of the Notice of Privacy Practices.

Patient Name: ______________________________ Date: __________

Patient/Parent Signature: ______________________________

(OVER)

ENDODONTIC CONSENT AND INFORMATION FORM

We want our patients to be informed about the various procedures and risks involved in endodontic (root canal) therapy and to have their consent before starting treatment. Endodontic therapy is performed in order to save a tooth which otherwise might need to be removed. Determination of the need for endodontic therapy is made after a review of your signs, symptoms and radiographs (x-rays) as well as information provided by your general dentist. The following discusses the possible risk that may occur during or following treatment.

MEDICATION RISK

Prescribed medications may cause drowsiness, lack of awareness and/or coordination. These effects may be compounded by the use of alcohol or additional medications. It is not advisable to operate any vehicle or machinery until you have recovered from the effects of medication. In addition, antibiotics have been reported to reduce the effectiveness of birth control pills in women. Additional methods of contraception are advised during the menstrual cycle in which the antibiotic is used.

RISKS SPECIFIC TO NONSURGICAL ENDODONTIC TREATMENT

Include but are not limited to discomfort, infection and swelling. Damage to bridges, crowns or existing fillings and/or loss of tooth structure in gaining access to the canals, the possibility of small instruments breaking within the root canal and/or perforations (extra openings) in the crown or root of the tooth. During treatment complications may be discovered which require endodontic surgery or extraction. You will be advised of complications such as blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, gum disease, and split or fractured teeth. These risks are in addition to the usual risks of general dental treatment and local anesthetic administration.

RISKS SPECIFIC TO SURGICAL ENDODONTIC TREATMENT

Include but are not limited to bleeding, discomfort, infection, swelling, sinus involvement, injury to other roots, and injury to nerves underlying the teeth resulting in numbness or tingling of the teeth, gums, lip, and/or tongue.

OTHER TREATMENT CHOICES

No treatment; waiting for more definitive signs or symptoms; tooth extraction. Risks of these choices include pain, infection, swelling and/or loss of teeth. If root canal treatment is started and not completed these same risks apply.

CONSENT

I, the undersigned, being the patient (or parent or guardian of minor patient) consent to the procedures decided upon to be necessary or advisable in the opinion of the doctor. I also understand that upon completion of root canal therapy I shall return to my general dentist for a permanent restoration of the tooth. I understand that root canal therapy is an attempt to save a tooth which would otherwise be extracted. Although this treatment has a high degree of success it cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatmenr, surgery or even extraction. I have read and understand the above.

Patient/Parent Signature ______________________________ Date ______________