

Vienna Endodontics

Dr. Albert A. Citron, DMD and Dr. Fernando J. Meza, DMD

Patient Information:

Name: _____ Social Sec.# _____

Home Phone: _____ Cell Phone: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

(Please Circle) Sex: **Male** **Female** Relationship Status: **Single** **Married** **Widowed** **Separated** **Divorced**

Employer: _____ Business Phone: _____

Who may we thank for referring you? _____

Notify in case of Emergency: _____ Phone: _____ Relationship: _____

Primary Insurance:

Policy holder name: _____ Social Sec.#: _____

Date of Birth _____ Relationship to Patient: _____ Employer: _____

Insurance Company Name: _____ Insurance Phone: _____

Subscriber #: _____ Group #: _____

Additional Insurance:

Policy holder name: _____ Social Sec.#: _____

Date of Birth _____ Relationship to Patient: _____ Employer: _____

Insurance Company Name: _____ Insurance Phone: _____

Subscriber #: _____ Group #: _____

Patient/Guardian Signature: _____ Date: _____

Medical History:

How would you describe your health? Please circle one: **Excellent Good Fair Poor**

When was your last physical examination? _____

Are you currently being treated for any illnesses or medical conditions? _____

If yes, please explain: _____

Physician's name: _____ Phone number: _____

Have you ever had any kind of surgery? **Y N** Please explain: _____

Have you ever had trouble with prolonged bleeding after surgery? **Y N**

Do you have a pacemaker? **Y N**

Have you had hip or other joint replacement surgery? **Y N** Please explain: _____

Are you currently taking any medications, drugs, herbs? **Y N**

If yes, please list: _____

Do you have any drug allergies? **Y N** Please list: _____

Have had an unusual reaction to anesthetic? **Y N** Please explain: _____

Are you allergic to Latex? **Y N** If you are female are you pregnant? **Y N**

Please circle any present or past illnesses listed below:

Alcoholism	Diabetes (Type : _____)	Hepatitis (Type : _____)	Mental
Allergies	Drug Dependency	Herpes	Migraine
Anemia	Epilepsy	HIV+	Respiratory
Asthma	Glaucoma	Immunodeficiency	Rheumatic Fever
Blood Pressure (High / Low)	Head/Neck injury	Infectious Disease	Sinusitis
Cancer (Type : _____)	Heart Disease	Kidney	Ulcers
		Liver	Venereal Disease

Is there anything else we should know about your health? **Y N**

If yes, please explain: _____

Signature Patient/Guardian: _____ Date: _____

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Financial Agreement:

While we try to do our best to accurately estimate your insurance benefits and co-payment, we cannot guarantee the final payment amounts, because they are determined by your insurance company. We collect your estimated co-payment at the time of our service. As a courtesy to you we will then bill your insurance company. Your insurance company may take up to 4 weeks to process payment. Any portion not paid by your insurance company after 4 weeks will then become your responsibility and payable within 30 days.

If the balance owed is not paid within 90 days we will begin the collection process with an outside agency. You will be responsible for the collection fees, as well as your overdue balance.

Please sign below to indicate that you understand and agree to these conditions.

Patient Name: _____ Date: _____

Signature Authorization:

In order to provide guarantee of payment for services provided, it is the policy of this office to request a credit card signature on file. Please review the authorization below and provide the necessary information. This form will be destroyed once your account is settled.

I authorize the office of Dr. Albert A. Citron and Dr. Fernando J. Meza to keep my signature on file as a guarantee of payment and to charge my credit card account for the balance of the charges not covered by insurance after I have satisfied my **estimated co-payment**.

We will notify you prior to charging your credit card if the balance is greater than \$100.00. We will not notify you if the balance is less than \$100.00. You will then be automatically charged for the remaining balance to your credit card, after the Insurance has paid their portion.

Patient Name: _____ Cardholder Name: _____

Cardholder Street Address: _____

City: _____ State: _____ Zip: _____

Card Number : _____ Exp: _____

(Circle one that applies :)

VISA MasterCard Discover American Express

Cardholder Signature: _____ Date: _____

Consent to Endodontic Therapy

We are concerned not only about your dental health and endodontic treatment needs, but also about your right as a patient to make the treatment decision that you feel is best for you. Our commitment to you is to provide you with detailed and reasonably complete information about your dental needs which we diagnose. We will share our diagnostic findings and opinions with you. We welcome all of your questions regarding our proposed treatment and/or as treatment progresses.

Towards this aim of a mutual sharing of information we feel it is important to advise you of the reasonably foreseeable risks of endodontic therapy. The following is important information you should consider in making your decision about treatment:

- Although root canal therapy has a very high degree of success, it is a biological procedure and therefore the results cannot be guaranteed. During root canal therapy there is the risk of instrument separation within the root canal anatomy; perforations (extra openings); damage to bridge(s), existing filling(s), crown(s), or porcelain veneer(s); missed canals, loss of tooth structure in gaining access to canals; and fracture of the tooth. Occasionally a tooth that has undergone root canal therapy may require re-treatment, apical surgery, or even extraction.
- Other treatment choices may include: no immediate treatment, waiting for more definitive symptoms to develop, or tooth extraction. Risks involved with these choices may include but are not limited to, pain, swelling, infection, and loss of tooth.
- Final restoration (Crown) of the tooth that has undergone root canal therapy is essential for retention of the tooth. A final restoration by your general dentist should be completed as soon as possible because delay may cause tooth fracture or possible loss of tooth.
- Local anesthesia (a “Novocaine” injection), is used to numb the tooth and surrounding tissues. I agree to the use of local anesthesia depending upon the judgment of Dr. Citron or Dr. Meza. Complications of root canal therapy and local anesthesia may include swelling, pain, trismus (restricted jaw opening), infection, bleeding, sinus involvement, numbness or tingling of the lip or tongue, which is rarely prolonged and even more rarely permanent. I understand that it is my responsibility to report any such symptoms to Dr. Citron or Dr. Meza immediately.
- If you have any unexpected or uncomfortable side effects from prescribed or recommended medications, Dr. Citron or Dr. Meza should be notified so they may advise you.

Patient/Guardian Signature: _____ Date: _____

Notice of Privacy Policy and Patient Acknowledgement

We are committed to providing you with the quality care, including protecting the confidentiality of your personal medical and treatment information. In response to that commitment and in accordance with new federal legislation, we would like to provide you with written notification regarding our office privacy policy and the necessary uses and disclosure of your information.

- We may use your information to provide you with treatment. In treating you for a specific condition, we may need to know if you have allergies or are taking any medications that may affect your treatment in our office, or could interfere with medications we may prescribe.
- We may use your information to provide you with quality care. We may need to review your treatment plan with authorized staff and provide information to other healthcare offices to ensure excellent communication with all of those involved in caring for you.
- We may use your information so that payment for treatment can be processed. Personal information, office visit dates, codes identifying treatment and diagnosis are required for accurate documentation and processing financial information for payment by you and your insurance company.

We may contact you to provide appointment reminders, information regarding your treatment, and to discuss financial information.

We will not, unless required by law, share your protected information with any other agencies without written authorization.

Patient Acknowledgement:

In accordance with federal legislation, I have read and received notice of this privacy policy and understand I do not have to give written permission for these uses of my protected information. I have the right to inspect and copy protected information, to receive confidential communications regarding protected information, to complain if I believe my privacy rights have been violated, and to receive a copy of this Notice of Privacy Policy upon request.

Patient/Guardian Signature: _____ Date: _____