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Account # _____

PATIENT REGISTRATION

PATIENT INFORMATION:

Name _____ (FIRST NAME) _____ (M.I.) _____ (LAST NAME) Sex: ❑ Male ❑ Female

Home Address _____ Social Security # _____

City _____ State _____ Zip _____ Birthdate _____ Age _____

Home Phone (_____) _____ Mobile Phone (_____) _____

Name of General Dentist _____ (FIRST NAME) _____ (LAST NAME) Years as a Patient _____

E-Mail Address _____

EMPLOYMENT INFORMATION:

Business Name _____ Business Phone (_____) _____

Address _____ Business Extension _____

City _____ State _____ Zip _____

IF THE PATIENT IS A MINOR:

Parent / Legal Custodian Name _____ (FIRST NAME) _____ (LAST NAME) Home Phone (_____) _____

Home Address _____ School Attending _____

City _____ State _____ Zip _____

EMERGENCY INFORMATION:

Emergency Contact _____ Relationship _____

Address _____ Phone Number (_____) _____

PRIMARY INSURANCE INFORMATION:

Insured's Name _____ (FIRST NAME) _____ (LAST NAME)

Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent

Insured's SSN _____

Insured's Birthdate _____

Dental Insurance Carrier _____

Address _____

City _____ State _____ Zip _____

Phone (_____) _____

Group or Local # _____

Insured's Employer _____

SECONDARY INSURANCE INFORMATION:

Insured's Name _____ (FIRST NAME) _____ (LAST NAME)

Relationship to Patient: ❑ Self ❑ Spouse ❑ Parent

Insured's SSN _____

Insured's Birthdate _____

Dental Insurance Carrier _____

Address _____

City _____ State _____ Zip _____

Phone (_____) _____

Group or Local # _____

Insured's Employer _____

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HEALTH HISTORY

Thank you for taking the time to fill out this form completely. This information will enable us to provide you with a thorough evaluation and quality treatment. Your complete comfort and satisfaction are our primary concern.

Are you under the care of a medical doctor for any illness or health problem (for the last two years)? ❑ Yes ❑ No

Medical Doctor Name _____ (FIRST NAME) _____ (LAST NAME) Phone (_____) _____

Reason for Exam _____

Do you have, or have you had, any of the following health conditions? Please provide information for all yes answers.

1. Congenital heart disease / Artificial heart valve. . . . ❑ Yes ❑ No
2. Bacterial / Infective endocarditis . . . ❑ Yes ❑ No
3. Heart murmur . . . ❑ Yes ❑ No
4. Heart surgery / Heart attack / Angina / Heart pacemaker . . . ❑ Yes ❑ No
5. High / low blood pressure . . . ❑ Yes ❑ No
6. Have you ever taken bone-enhancing drugs (Zometa, Aredia, Fosamax, Actonel, Boniva, Skelid, Bonefos, Ostac, Didronel). . . . ❑ Yes ❑ No
7. Stroke . . . ❑ Yes ❑ No
8. Artificial joints: ❑ Hip ❑ Knee ❑ Other _____ ;if yes, when _____ . . . ❑ Yes ❑ No
9. Fainting spells / Seizures / Epilepsy . . . ❑ Yes ❑ No
10. Diabetes . . . ❑ Yes ❑ No
11. Cancer; if yes, type and when _____ . . . ❑ Yes ❑ No
12. Kidney trouble . . . ❑ Yes ❑ No
13. Lung disorders / Tuberculosis / Asthma / Emphysema / Etc. . . . ❑ Yes ❑ No
14. Blood disorders such as Anemia. . . . ❑ Yes ❑ No
15. Abnormal amount of bleeding. . . . ❑ Yes ❑ No
16. Severe infection . . . ❑ Yes ❑ No
17. Hepatitis / Jaundice / Liver disease. . . . ❑ Yes ❑ No
18. Cold sores . . . ❑ Yes ❑ No
19. Immune disorder (Lupus, HIV, ARC, AIDS) . . . ❑ Yes ❑ No
20. TMJ (temporal mandibular joint pain) . . . ❑ Yes ❑ No
21. If you are a woman, are you pregnant or breast feeding . . . ❑ Yes ❑ No
22. List of major surgeries or hospitalizations

_____

23. Do you have any disease, condition, or handicap not listed above . . . ❑ Yes ❑ No
24. Are you taking medications, prescriptions, or over-the-counter drugs . . . ❑ Yes ❑ No
    If yes, please list

25. **Do you have allergies or adverse side effects** to local anesthetics (Lidocaine), latex, Penicillin, Codeine, or any other medications? . . . ❑ Yes ❑ No
    If yes, please list

_____

I, undersigned, being the patient, parent or guardian of the above minor patient, do state that the above information is to the best of my knowledge accurate, and I hereby consent to any necessary diagnostic procedures considered valuable by the doctor. I also understand upon completion of root canal therapy in this office, I will be referred to my general dentist for permanent restorations (crown, onlay, or filling) of the involved tooth.

I acknowledge that I am under the care and supervision of my treating endodontist and not any other dentist. I further acknowledge that I am relying soley upon his knowledge, skill, and expertise.

Print Patient's Name _____ Birthdate _____

For Minors, Print Legal Custodian / Guardian's Name _____

Patient's Signature (guardian if minor) _____ Today's Date _____

Doctor's Review _____ Date _____ Patient Review _____ Date _____

Doctor's Review _____ Date _____ Patient Review _____ Date _____

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PATIENT SELF ASSESSMENT

Today's Date 11/29/2017

Patient Name _____ (FIRST NAME) _____ (LAST NAME) Birthdate _____

Please tell us the reason for your visit today _____

_____

1. Please check your current level of pain:

   no pain ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 severe pain

2. If you are currently experiencing pain, or have had previous pain, with your tooth, please check the best description of the area:

   ❑ Upper right portion of the mouth ❑ Upper front teeth ❑ Upper left portion of the mouth

   ❑ Lower right portion of the mouth ❑ Lower front teeth ❑ Lower left portion of the mouth

   ❑ Pain limited to one specific tooth ❑ Pain from several teeth

3. Please check the word(s) that best describe your pain:

   ❑ Sharp ❑ Throbbing ❑ Continuous ❑ Burning

   ❑ Dull ❑ Aching ❑ Intermittent ❑ Itching ❑ Other _____

4. How long have you experienced this pain? _____

5. Is the pain getting:

   ❑ Better ❑ Worse ❑ Less frequent ❑ More frequent ❑ Staying the same

6. What makes your pain worse (check the word that best describes it): _____

   ❑ Heat ❑ Cold ❑ Chewing ❑ Other

7. What makes the pain better? _____

8. Has there been any swelling associated with the tooth: ❑ Yes ❑ No

9. Please list any dental work done in the area of pain within the past 6 months:

Doctor's Notes

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INFORMATION ABOUT ENDODONTIC TREATMENT (ROOT CANAL)

We would like our patients to be informed about the various procedures involved in endodontic therapy and have their consent before starting treatment. Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by conservative root canal therapy, or when needed, endodontic surgery. The following discusses possible risks that may occur from endodontic treatment, and other treatment choices.

RISKS

Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics and injections. These complications include: swelling; sensitivity; bleeding; pain; infection; numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth; reaction to injections; changes in occlusion (biting); muscle cramps and spasms; temperomandibular (jaw) joint difficulty; loosening of teeth; referred pain to ear, neck and head; nausea; vomiting; allergic reactions; delayed healing and sinus complications.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY

These risks include the possibility of instruments broken within the root canals; perforations (extra openings) of the crown or root of the tooth; damage to bridges, existing fillings, crowns or porcelain veneers, loss of tooth structure in gaining access to canals, and cracked teeth. During treatment complications may be discovered which may make treatment impossible, or which may require dental surgery. These complications may include: blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), splits or fractures of the teeth.

OTHER TREATMENT CHOICES

These include no treatment, waiting for more definitive development of symptoms, having the tooth removed. In some circumstances the removed tooth may be replaced with an implant. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infection to other areas.

MEDICATIONS

Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol or other drugs). Thus it is not advisable to operate any vehicle or hazardous device until recovered from their effects.

CONSENT FOR TREATMENT

I, the undersigned, being the patient (parent or guardian of aforementioned minor patient) consent to the performing of procedures and authorize the administration of such drugs and/or anesthetics as may be deemed necessary or advisable in the opinion of the Doctor. I further authorize them to do whatever they deem necessary or advisable as a result of unforeseen circumstances. I also understand that upon completion of root canal therapy in this office I will be directed to return to my general family dentist for a permanent restoration of the tooth involved, such as a post and/or crown, core build-up, composite, or amalgam filling.

❏ Patient accepts recommended endodontic treatment plan

❏ Patient declines recommended endodontic treatment plan

X _____ **X** _____

Signature of patient *(Parent or Guardian if Minor)* **Date**

X _____ **X** _____

Witness **Date**

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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

I, _____ , have received a copy of the Dental Materials Fact Sheet.

Print Name of Patient or Personal Representative: _____

Personal Representative's Title: _____
(e.g. Guardian, Estate Executor, Health Care Power of Attorney)

Signature: _____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

• *You May Refuse to Sign This Acknowledgment* •

I, _____ , have received a copy of this office's Notice of Privacy Practices.

Print Name of Patient or Personal Representative: _____

Personal Representative's Title: _____
(e.g. Guardian, Estate Executor, Health Care Power of Attorney)

Signature: _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❏ Individual refused to sign
- ❏ Communications barriers prohibited obtaining the acknowledgement
- ❏ An emergency situation prevented us from obtaining acknowledgement
- ❏ Other (Please Specify):

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FINANCIAL AGREEMENT

The primary objective of this office is to provide you with the best quality dental care available. This document serves as an agreement between Placer Endodontics, and you, the patient/legal guardian. Our objective is to provide comprehensive information in order to alleviate any misunderstandings with regard to our financial agreement.

PATIENT FINANCIAL LIABILITY

Private Pay Patients: You are responsible for full payment of consultation and treatment fees **at time of service.**

Insurance Patients: Acceptance of assignment of benefits by this office **does not absolve you of full responsibility for charges** for the treatment rendered. **We require a down payment of 30% of the total fees for treatment rendered at the time of service.** Your down payment is to be considered only as a guideline until the final insurance payment is received and the patient's account has been reconciled. **It is the patient's responsibility to be knowledgeable of their dental insurance coverage, their maximum dollar amount per year, and the amount of unused coverage for their calendar year.**

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign to Placer Endodontics my right, title and interest in and to any and all dental, medical or other benefits otherwise payable to me for treatment provided by Placer Endodontics. I further authorize the release of information to my insurance carrier. I acknowledge that I am still responsible for paying Placer Endodontics if the relevant insurer, plan or payer does not pay practice in full at its billed amount.

X _____
Patient Initials

COLLECTION AGREEMENT

If necessary, we have your authorization to release a minimum amount of your patient information to collection agency(ies) to obtain payment of unpaid balances on your patient account.

X _____
Patient Initials

RETURNED CREDIT CARD, NSF CHECKS, FINANCE CHARGES, BROKEN APPOINTMENTS

There will be a **$25 fee assessed for any form of returned payment**, such as stop payments on credit cards and / or checks, and non-sufficient funds check returns. There will be a **$35 fee assessed for any refund checks lost by you.**

All accounts must be reconciled after treatment is complete. We do not carry payments in this office. A finance charge of 18% per annum will be applied to each account after 90 days. There will be a **$30.00 charge to send an account to an outside collection agency.**

We ask for your consideration in calling if you are unable to make an appointment. There will be an additional fee of **$100 if an appointment is broken with less than 24 hours notice.**

X _____
Patient Initials

CONSULTATION AND ROOT CANAL THERAPY FEES

We charge for root canal terapy by the tooth that is treated. Our fees are:

Endodontic Consultation	$130.00	Anterior Root Canal Retreatment	$1,050.00
Radiograph	$35.00	Insurance Patient's Down Payment	$315.00
Anterior Root Canal Therapy	$940.00	Premolar Root Canal Retreatment	$1,250.00
Insurance Patient's Down Payment	$290.00	Insurance Patient's Down Payment	$375.00
Premolar Root Canal Therapy	$1,095.00	Molar Root Canal Retreatment	$1,450.00
Insurance Patient's Down Payment	$330.00	Insurance Patient's Down Payment	$435.00
Molar Root Canal Therapy	$1,300.00	Post Removal	$300.00
Insurance Patient's Down Payment	$400.00	Composite Filling/Core Build-Up	$195.00

NOTE: If the tooth has previous endodontic therapy and conservative endodontic retreatment is necessary, we will bill your insurance company as aggressively as reasonable. It is important to note that this additional fee **may not be covered** by your dental insurance. Our fee does not include the permanent filling or crown to be completed by your own dentist after completion of endodontic treatment.

X _____
Patient Initials

PLEASE INDICATE BELOW THE FORM OF PAYMENT YOU WILL USE TODAY

❑ **Cash** ❑ **Check** ❑ **American Express / VISA / MasterCard / Discover** ❑ **Care Credit**

X _____ X _____
Signature of patient or financially responsible party *(Parent or Guardian if Minor)* **Date**

X _____ X _____
Placer Endodontic's staff signature **Date**