Patient Information

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Soc. Sec. #: _____ Home #: _____ Cell #_____

Whom may we thank for referring you? _____

Primary Dental Insurance Information

Person Responsible for Account: _____

Relationship to Patient: _____ Date of Birth: _____ Soc. Sec. #: _____

Person Responsible Employed by: _____

Business #: _____ Insurance Co.: _____

Insurance #: _____ Group #: _____ Subscriber #: _____

Dental History

Current Dentist: _____ Office #: _____

Date of last dental visit: _____Are you having any dental problems at this time? _____

If so, what problems? _____

Do you feel pain or popping of jaw joint when opening or closing your mouth? _____

If so, when did you first notice the occurrence? _____

Has anyone in your family had oral cancer? _____If so, who and when? _____

I have reviewed the information on the questionnaire and it is accurate to the best of my knowledge. I authorize the insurance company to issue payment directly to the dentist. I authorize the use of this signature for all insurance claims. I understand that I am responsible for all fees.

Signature: _____ Date: _____

WESTSHORE Endodontics

HEALTH INFORMATION

Do you have a history of:	Y	N		Y	N		Y	N		Y	N
Rheumatic Fever			Asthma			Thyroid Disease			Teeth Grinding or Clenching		
Heart Murmur			Allergies or Hives			Epilepsy or Seizures			Psychiatric Treatment		
Mitral Valve Prolapse			Anemia			Fainting or Dizzy Spells			Mouth Sores or Growths		
Diabetes			Alcoholism			Any Type of Implant			Aspirin or Anticoagulant Therapy		
Venereal Disease			Arthritis			Pain In Your Jaw			Ulcers or Stomach Problems		
High Blood Pressure			HIV Positive/AIDS			Latex Allergy			Pace Maker or Heart Surgery		
Low Blood Pressure			Blood Transfusion			Sinus Problems			Cancer (Type)		
Any Type of Transplant			Heart Problem			Excessive Bleeding			Any Artificial Hip, Knee or Other Joint		
Drug Addiction			Dialysis			Stroke			Other Disease or Illness:		
Hepatitis (Type)			Chemotherapy			Lung Disease					
Liver Disease			Radiation Treatment			Breathing Problems					
Kidney Disease			Use of Tobacco Products			Tuberculosis (TB)					

Please circle YES or NO, whichever applies. Your answers are for our records only and are considered confidential.

YES NO Do you consider yourself in good health at this time?

YES NO Have there been any changes in your general health in the last year?

YES NO Have you ever been instructed to take pre-medications before dental treatment?

YES NO Have you ever taken Phen-Fen or any other diet pills?

Do you have any of the following allergies?

YES NO Penicillin or other antibiotics

YES NO Aspirin or Ibuprofen

YES NO Sulfa drugs or Iodine

YES NO Codeine or other narcotic medications

YES NO Valium, sedatives or sleeping pills

YES NO Have you or any blood relative had any adverse reactions to local or general

Anesthetic? If YES, please provide more detail. _____

_____

Women:

YES NO Are you pregnant or is there a possibility or pregnancy at this time?

YES NO Are you currently a nursing mother?

Are you currently taking any of the following medications? Please list the medication and dosage.

YES NO Antibiotics

YES NO Anticoagulants (blood thinners)

YES NO Blood pressure medications

YES NO Steroids

YES NO Tranquilizers or Antihistamines

YES NO Aspirin, Ibuprofen or Naproxen (Aleve)

YES NO Insulin, Tolbutamide (Orinase) or other blood sugar altering medications

YES NO Digitals, Nitroglycerine or other heart medications

YES NO Oral contraceptives

YES NO Any other prescription medications

I understand that withholding any information about my health could seriously jeopardize my safety. Therefore I have reviewed this health history carefully and have answered all questions to the best of my knowledge.

_____ _____

Signature of Patient (or legal guardian) **Date**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY: West Shore Endodontics may be required by applicable federal and state law to maintain the privacy of your health information. Protection of patient privacy is important. This notice summarizes the privacy practices that will be followed by everyone at West Shore Endodontics, and your rights concerning your health information. This notice will apply to health information collected in connection with your treatment at West Shore Endodontics.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us.

USES AND DISCLOSURES OF HEALTH INFORMATION: We use and disclose health information about you for treatment. For example, we may use or disclose your health information to another dentist, physician or other health care provider providing treatment to you.

YOUR AUTHORIZATION: Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person involved in your treatment to the extent necessary to help with your healthcare.

PERSONS INVLOVED IN CARE: We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

MARKETING HEALTH-REALTED SERVICES: We will not use your health information for marketing communications without you written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

NATIONAL SECURITY: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions

or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

PATIENT RIGHTS ACCESS: You have the right to look at or get copies of your health information, with limited exceptions. Contact us using the information listed at the end of the notice for assistance in reaching the dentist or facility holding your health information.

DISCLOSURE ACCOUNTING: You may have the right to received a list of instances in which your health information was disclosed for purposes other than treatment or certain activities for the last 6 years, but not before April 14, 2003.

RESTRICTION: You may request that we place additional restrictions on our use or disclosure of you health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency)/

ALTERNATIVE COMMUNICATION: You may request that we communicate with you about your health information by alternate means or to alternative locations. We may agree to reasonable requests.

AMENDMENT: You may request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS: If you want more information about our privacy practices or have questions or concerns, please contact us. If you're concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services.

Signature: _____

Date: _____

OFFICE FINANCIAL POLICY

CONSULTATION APPOINTMENTS:

The charge for a consultation is $150.00, which is due on the day of service. If you decide to have treatment at the time of consult, the consult fee will be waived. Some dental groups do not pay for consultations. We file a claim for the consultation, with your insurance company, but reimbursement to the patient is not guaranteed. We accept VISA, MASTERCARD and DISCOVER.

FOR ALL INSURANCE PLANS:

We will bill your insurance company. Your estimated co-payment is due in full at the time of service. If the claim is not paid within 60 days or if there is any remaining balance after insurance pays, that amount is your responsibility and is due in full. The benefits belong to you and it is up to you to ensure that you are receiving appropriate reimbursement under the terms of your plan. There is not guarantee of benefits from the insurance company until a claim is received and processed. *Benefits quoted to you are only and estimate provided by the insurance coordinator.* Finance charges will be assessed on all accounts 60 days past due.

Patient Signature: _____

Date: _____

CONSENT FOR ENDODONTIC TREATMENT

I understand root canal treatment is a procedure to retain a tooth, which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed.

WESTSHORE Endodontics

I, the undersigned, have been informed that I require an endodontic procedure (root canal treatment) on tooth number _____ and that I fully understand the following:

- Failure to follow this recommendation will most likely result in:
    1. The loss of the tooth.
    2. Bone destruction due to an abscess.
    3. Possible systemic (affecting the whole body) infection.
- A certain percentage (5-10%) of root canals fail, and they may require re-treatment, periodical surgery or even extraction.
- During instrumentation of the tooth an instrument may separate and lodge permanently in tooth or an instrument may perforate the root wall. Although this is rarely occurs, such an occurrence could cause the failure of the root canal and the loss of the tooth.
- When making an access (opening) through an existing crown or placing a rubber dam clamp, damage could occur and a new crown would be necessary after endodontic therapy.
- Successful complication of the root canal procedure does not prevent future decay or fracture.
- Temporary fillings are usually placed in the tooth immediately after root canal treatment. Teeth which have had root canal treatment will require a permanent (outside) restoration. This may involve a filling or more extensive restoration work (pins, post, crown build-up, crown) depending on the clinical status of the tooth.

I understand that a series of appointments will be necessary to complete the root canal therapy, as well as other appointments for restoration. I am also aware that I may have continuing temporary symptoms throughout the treatment. Those symptoms may include: Swelling, drainage, pain, fever, infection and numbness. There are risks involved in administration of anesthetics, analgesics (pain medication) and antibiotics. I will inform the Doctor of any previous side effect or allergies.

Note: Antibiotics may decrease the effectiveness of birth control medication. Additional methods of birth control should be used while on antibiotics.

_____ _____

Patient or Patient's Guardian Signature Date

_____ _____

Witness to Signature Date

_____ _____

Doctor's Signature Date