ORLANDO ENDODONTIC SPECIALISTS | VOLUSIA ENDODONTICS

PATIENT INFORMATION

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. _____ Last Name _____

Nickname: _____ Primary Language: _____ *If needed, specify any translation needs:* _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Soc. Sec. # _____

Street _____ City _____ State _____ Zip _____

Home Tel. _____ Cell. _____ Work _____ Employer _____

Email _____ Emergency Contact _____ Tel. _____

General Dentist _____ Tel. _____ If Greenberg or Coast, which location _____

Who will be responsible for your account? ❑ Self (If self, skip to next section) ❑ Spouse ❑ Parent ❑ Other _____

First Name _____ M.I. _____ Last Name _____ Soc. Sec. # _____

Street _____ City _____ State _____ Zip _____

Home Tel. _____ Cell. _____ Work _____ Employer _____

DENTAL INSURANCE INFORMATION

Primary Insurance Company _____ Tel. _____ ❑ DMO/HMO ❑ PPO ❑ DELTA CARE

Group # _____ Group Name _____ Subscriber ID # _____

(If other than patient) Insured Party's First Name _____ Last Name _____ Relation _____

Street _____ City _____ State _____ Zip _____

Birth Date _____ Soc. Sec. # _____ Tel. _____ Employer _____

MEDICAL HISTORY **Have you ever had or do you currently have:**

Fibromyalgia	❑ Yes ❑ No	HIV	❑ Yes ❑ No	Cancer	❑ Yes ❑ No
Heart Murmur/Mitral Valve Prolapse	❑ Yes ❑ No	Angina/Heart Attack	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Heart Valve/Joint Replacement	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No
Rheumatic Fever	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Asthma	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No	Sinus Problems	❑ Yes ❑ No
Hepatitis/Liver Disease	❑ Yes ❑ No	Thyroid Disease	❑ Yes ❑ No	Substance Abuse	❑ Yes ❑ No
Irritable Bowel / Ulcerative Colitis	❑ Yes ❑ No	Bruising/Bleeding Problems	❑ Yes ❑ No	Mental Health Prob	❑ Yes ❑ No
Penicillin Allergy	❑ Yes ❑ No	Stomach Ulcers	❑ Yes ❑ No	Other Condition	❑ Yes ❑ No
Latex Allergy	❑ Yes ❑ No	Tuberculosis/Lung Problem	❑ Yes ❑ No		

Has your physician/cardiologist instructed you to premedicate with antibiotics prior to a dental appointment? ❑ Yes ❑ No

If Yes to any, please explain: _____

Are you currently Pregnant or Nursing: ❑ Yes ❑ No

Medications presently taking (bone density medications, bisphosphonates, blood thinners, vitamins, supplements, others):

_____

Allergic to any drugs or medications & describe reaction to it: _____

I certify that the above information is correct:

_____ _____

Patient Signature (or guardian of a minor) **Date**

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Acknowledgement of Receipt of Notice of Privacy Practices

Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), you have certain rights to privacy regarding your protected health information. You understand that this information can and will be used to:

- Conduct, plan and direct your treatment and follow-up among the health care providers who may be involved in that treatment directly or indirectly
- Obtain payment from third-party payers
- Conduct normal health care operations such as the business aspects of running the practice on a daily basis

By signing this you acknowledge you have received, read, and understand our Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. You understand we reserve the right to change our privacy practices as described in the Notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

For Orlando Endodontic Specialists practices (Downtown Orlando, Kissimmee, Longwood, & Waterford Lakes):

Contact Person: Office Manager Telephone: 407-423-7667 Fax: 407-425-8629 Address: 610 N. Mills Ave., Suite 210, Orlando, FL 32803

For Volusia Endodontics practices (Daytona & Orange City):

Contact Person: Office Manager Telephone: 386-789-3636 Fax: 386-789-3637 Address: 2751 Enterprise Rd., Suite 211, Orange City, FL 32763

Right to Restrict: You may request in writing that we restrict how your private information is used or disclosed to carry out treatment, payment, or health care options. You also understand we are not required to agree to your requested restrictions, but if we do agree then we are bound to abide by such restrictions.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature: _____ **Date:** _____

Print Name:_____ **(specify if __ parent/guardian)**

***You May Refuse to Sign This Acknowledgement**

FOR OFFICE USE ONLY

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

☐ 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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INFORMED CONSENT FOR ENDODONTIC TREATMENT

You have been referred to our specialty office because you may need to receive endodontic therapy. The need for this therapy is mostly due to trauma (often from a cavity, large restoration, or fracture) to your tooth, which has compromised the health of the pulp tissue. Endodontic (root canal) therapy is performed to relieve your current symptoms and save a tooth which might otherwise need to be removed. The therapy is accomplished by conventional endodontic therapy (removal of the nerve tissue and the sealing of the space that is created in the canal in order to relieve or prevent infection in the root of your tooth), or when needed, endodontic surgery. We do not do oral cancer screenings.

We would like our patients to be informed about the various procedures and risks involved in endodontic therapy/surgery versus other treatment choices. You will be required to sign this consent prior to your evaluation, **however it does not commit to you opting for treatment**. It serves to acknowledge that you may ask any questions and have been informed and understand the following:

RISKS OF ANY DENTAL PROCEDURE: Included, but not limited to, are: allergic reactions or complications from the methods and use of dental instruments, dental materials, medications and injections. Complications may include swelling, bruising, sensitivity, bleeding, pain, itching, infection, tooth discoloration, restricted jaw opening, delayed healing, changes in the occlusion (biting), jaw pain or restricted opening, facial/neck muscle cramps and spasms, and numbness or tingling in the face and mouth. On infrequent occasions, development of an abscess, loosening of teeth, referred pain to the ear, neck or head, nausea, or sinus perforations may occur.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY AND SURGERY: Included, but not limited to, are: the possibility of instruments breaking within the root canals, the possibility of broken instruments or debris within or surrounding the root, perforations (extra opening) of the crown or root of the tooth, damage to bridges, existing fillings, crowns, porcelain veneers, loss of tooth structure, cracked teeth, injury to soft tissues or nerves near the tooth, and small root fragments remaining. **If it is necessary to access the root through an existing crown, you may require a new crown.** Your general dentist will determine if a new crown is required. During the procedure, complications may become apparent which make treatment impossible, or which may require dental surgery or extraction (removal of the affected tooth). These complications include inability to access to the tooth needing treatment, blocked canals due to fillings or prior treatment, curved or narrow canals, natural calcifications, broken instruments, periodontal disease, resorptive defects, and fractures (cracks) of the teeth.

MEDICATIONS: Prescription medications may cause ineffectiveness of birth control pills, drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol or other drugs). It is not advisable to operate any vehicle or hazardous devices until you have recovered from their effects.

OTHER TREATMENT CHOICES: These include no treatment, waiting for more definite development of symptoms, or tooth extraction. All of these choices, and the choice not to complete the root canal treatment once it has begun, carry risks of their own including, but not limited to: severe pain, infection and swelling, cyst formation, systemic disease, and loss of this tooth and possibly other teeth. Extraction frequently needs to be followed by a bridge, partial denture, or an implant to prevent shifting of the other teeth so that there will be an even distribution of the forces during chewing, and to keep a full appearance of the face. All these restorations are at an additional cost to the cost of extraction.

_____**Patient Initials**

INSURANCE: As a courtesy to you, we participate in many insurance plans, but our professional services are rendered and charged to you, not your insurance company. Your insurance policy is a contract between you/your employer/your insurance company, but not our office. However, if insurance information is provided prior to your treatment and verification is obtained, we will accept assignment for the insurance portion of the benefits. Before treatment is performed, we collect payment of any deductible amount, co-pay, or other estimated amount not covered by your insurance company. **Any portion of the fee not covered by your insurance is your responsibility.** Our office will not enter into a dispute with your insurance company over any claim. All fees charged via attempts to collect any patient portion will be the financial responsibility of the patient or guardian. It is your responsibility to file any medical claims, workman's comp, secondary insurance, COBRA, or government/military insurance.

Although the endodontic therapy performed will be performed in a manner which will minimize and avoid risks and has a high degree of clinical success, it is still a biological procedure and cannot be guaranteed. Various factors that cannot be controlled contribute to the success of the therapy, which include, but are not limited to: your general health, your healing capacity or resistance to infection, adequate gum attachment and bone support, the anatomy, condition and location of the roots, habitual clenching and grinding, the force with which you bite and a fracture of the treated tooth. If we detect a fracture in a tooth and still recommend treatment, be aware that in spite of treatment some cracks may continue to progress, ultimately resulting in loss of the tooth. However, treating the cracked tooth is still important because it will relieve pain and reduce the likelihood that the crack will worsen.

Rarely, a tooth that has had endodontic therapy may not relieve your pain and symptoms totally, and may require retreatment, surgery, even extraction, or treatment of another tooth. There will be a full charge for all completed cases, regardless of success or failure. If a treatment cannot be completed due to a complication, there will be a charge for all procedures performed up to that point.

It is your responsibility to seek attention should any undue circumstances occur postoperatively and diligently follow any preoperative and postoperative instructions given to you. **UPON COMPLETION OF THE ENDODONTIC PROCEDURE, YOU MUST PROMPTLY (in no case longer than 30 days) RETURN TO YOUR GENERAL DENTIST FOR PERMANENT RESTORATION OF THE TOOTH, (the cost of which is not included in our fee).**

I have read, acknowledge and understand the content of this document. I consent to allow and authorize the dentist and/or his staff to perform any examinations, diagnostic procedures, and render any treatment or medications necessary or advisable to my dental condition as it stands now or as it arises during treatment.

_____ _____

Patient Signature (or guardian of a minor) **Date**