PRECISION ENDODONTICS

Patient Information:

Patient Name: ____ Birthdate: __________________

Street Address: ____

City: _________________________ State: _______________ Zip Code: ___________________

Home Phone: __________________________ Cell Phone: ___________________________

Employer: ______________________________ Business Phone: __________________________

Email: ____

Occupation: ______________________________ Social Security Number: ____________________

Spouse's name (if applicable): ____

Spouse's Employer: ___________________________ Business Phone: __________________________

Parent/Guardian Name (if minor): ____

Parent/Guardian Employer: ____________________ Business Phone: __________________________

If minor, who is legally responsible for treatment/financial decisions: ______________________________

In case of emergency, who should we contact: ____

Phone: ____________________________________ Relationship: ___________________________

Insurance Information:

Insurance Company Name: ____

Insurance Address & Phone Number: ____

Subscriber's Name & DOB: ____

ID/SSN Number: ___________________________ Group/Policy Number: _____________________

Secondary Company Name (if applicable): ____

Insurance Address & Phone Number: ____

Subscriber's Name & DOB: ____

ID/SSN Number: ___________________________ Group/Policy Number: _____________________

I understand that insurance coverage and out of pocket costs provided to me are an estimate and not a guarantee of insurance payment.

Patient/Parent Signature: ____ Date: _______________

HEALTH HISTORY

Name of referring dentist: ___________________________________ Phone: _____________________

Name of physician: ____ Phone: _____________________

Approximate date of last physical exam: ____

1. Have you had surgery or treatment for a tumor, growth, or other condition of the head, mouth or lips? Yes No

2. Are you under the care of a physician for specific medical problems? Yes No

3. Have you ever had serious illness or major operations? Yes No

4. Are you taking any medications regularly? (Prescription or OTC) Yes No

   ____
   ____
   ____
   ____

5. Have you had an adverse reaction or allergy to any of the following:

   a. Aspirin Yes No
   b. Dental anesthetics Yes No
   c. Anti-inflammatory medications Yes No
   d. Penicillin or other antibiotics Yes No
   e. Codeine or other pain medications Yes No
   f. Latex materials Yes No

6. Are there any medications you cannot take? If so, please list:
   ____

7. Have you ever had abnormal bleeding or difficulty with clotting after a wound? Yes No

8. Do you smoke: Yes No

9. Please circle if you have had any of the following:
   a. Alcoholism/Drug dependency
   b. Artificial joints/Prosthetic implants
   c. Bacterial Endocarditis
   d. Cancer
   e. Cardiovascular disease
   f. Diabetes
   j. Heart murmur
   k. Hepatitis/Jaundice
   l. High/low blood pressure
   m. HIV/AIDS
   n. Kidney issues
   o. Mitral valve prolapse

g. Emphysema
h. Epilepsy
i. Glaucoma
p. Organ transplant
q. Prosthetic cardiac valves
r. Prostate disorders

Continued on next page

s. Radiation therapy
t. Rheumatic fever
u. Seizures or convulsions
v. Stroke
w. Syncope/tendency to faint
x. Tuberculosis
y. Ulcers
z. Venereal disease

10. Are you taking female hormones (oral contraceptives, etc.)? Yes No

11. Are you currently pregnant or nursing? Yes No

Patient/Parent Signature: ______________________________________ Date: ____________

FINANCIAL AGREEMENT

By signing below, I acknowledge my responsibility of payment for the services received from Precision Endodontics in accordance with their regular fees and terms. My responsibility is not modified by whether my third party (insurance carrier) pays for all, part or none of the charges. I understand that this account becomes delinquent if not paid within 60 days after billing and that at this time a finance charge of 1.5% of the unpaid balance will be charged every month until balance is paid in full. 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 and release: *I authorize payment to be made directly to the dentist by my insurance company and I accept financial responsibility for all services not covered by my insurance and authorize release of any medical care information requested by my insurance carrier.*

Patient/Parent Signature: ____ Date:_______________

ENDODONTIC CONSENT AND INFORMATION FORM

We want our patients to be informed about the various procedures and risks involved with 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 imaging, as well as information provided by your general dentist. The following discusses the possible risks that may occur during or following treatment:

MEDICATION RISK

Prescribed medication may cause drowsiness, lack of awareness, and/or coordination. These effects may be compounded by the use of alcohol or additional medication. It is not advisable to operate any vehicle or machinery until you have recovered from the effects of mediation. 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.

NONSURGICAL ENDODONTIC TREATMENT

Risks 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 such as blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, gum disease, and split or fractured teeth may occur. These risks are in addition to the usual risks of general dental treatment and local anesthetic administration.

SURGICAL ENDODONTIC TREATMENT

Risks 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 or tooth extraction. Risks of those 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/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 treatment 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 retreatment, surgery or even extraction. I have read and understand the above.

Patient/Parent Signature: ____ Date: _______________

PRECISION ENDODONTICS

4225 Hoyt Ave. Suite B

Everett, WA 98203

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment. directly or indirectly.
- Obtain payment from third-party payers (insurance companies).
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that Precision Endodontics restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that Precision Endodontics is not required to agree to my requested restrictions, but if Precision Endodontics does agree they are bound to abide by such restrictions.

Patient Name: ____

Patient/Parent Signature:____ Date: ______________