EDGEWOOD
ENDODONTICS

Thank you for choosing Edgewood Endodontics! We look forward to taking care of you. Please complete the forms below so that we may better serve your needs.

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. This office does not use this information to discriminate.

Patient Name _____ **DOB** _____**SSN**_____

Address_____ **City** _____**State**_____ **Zip**_____

Home:_____ **Work:**_____ **Cell:**_____

Email:_____ **Employer:**_____

Marital Status: ☐Single ☐Married

Emergency Contact Name:_____ **Phone**: _____

Relationship to Patient:_____

Address:_____

I consent to the release of my PHI (personal health information) protected by HIPAA (Health Insurance Portability and Accountability Act) to be shared with the following person(s):

Name: _____ Relationship to Patient: _____

Phone: _____ Address: _____

Patient Signature: _____ Date: _____

PAYMENT IN FULL IS EXPECTED AT THE TIME SERVICES ARE RENDERED

The insurance contract is between the patient and the insurance company and thus any reimbursement will come directly from the insurance company. We will file the claim with your insurance company to help you receive your maximum allowable benefits.

Dental Insurance Company:_____**Member ID #**_____ **Group #**_____

Policy Holder (if other than insured): _____

Policy Holder DOB: _____ **Policy Holder SSN:** _____

Are you currently under a general dentist or specialty care? __Y __ N If yes, please provide

physician's name and phone number:

_____

Have you ever been hospitalized or had a major operation?__Y __ N If yes, please explain:

_____

Have you ever had a serious head or neck injury? __Y __ N If yes, please explain:

_____

Are you taking any medications, Pills, or Drugs? __Y __ N If yes, please explain:

_____

_____

Do you use tobacco? __Y __ N **Do you use controlled substances?** __Y __ N

Are you ALLERGIC to any of the following?

- ☐Aspirin
- ☐Penicillin or other antibiotics_____
- ☐Codeine or other narcotics_____
- ☐Metal
- ☐Latex
- ☐Local Anesthetic
- ☐Other_____
- ☐Bleach
- ☐Sulfa
- ☐Iodine/seafood

Have you ever been advised to take antibiotics before dental treatment? __Y __ N

Do you have any of the following? Check all that apply

Cardiovascular Disease
Angina
Arteriosclerosis
Congestive Heart Failure
Damaged Heart Valves
Heart Attack
Heart Murmur
Low Blood Pressure
High Blood Pressure
Other Congenital Heart Defects
Mitral Valve Prolapse
Pacemaker
Rheumatic Fever
Rheumatic Heart Disease
Abnormal Bleeding
Anemia
Blood Transfusion
Hemophilia

AIDS / HIV Infection
Arthritis
Autoimmune Disease
Rheumatoid Arthritis
Systemic Lupus
Erythematosus
Asthma
Bronchitis
Emphysema
Sinus Trouble
Tuberculosis
Cancer / Chemo
Radiation Treatment
Chest Pain Upon Exertion
Chronic Pain
Diabetes Type I or II
Eating Disorder
Malnutrition

Gastrointestinal Disease
Thyroid Problems
Stroke
Glaucoma
Hepatitis
Liver Disease / Jaundice
Epilepsy
Fainting Spells
Seizures
Neurological Disorders
Specify:_____
_____
Mental Health Disorders
Specify:_____
_____
Recurrent Infections
Types of Infection:_____
Pregnant or Nursing

Root Canal Informed Consent

_____I understand root canal therapy has a high degree of success–about 90% success at five years. However, success cannot be guaranteed. Occasionally, a tooth that has had a root canal may require retreatment, surgery or even extraction.

_____I have been informed and understand there are certain inherent and potential risks in any treatment procedure. These include swelling, bruising, discomfort, infection, and numbness of tongue or tingling of the lips and/or jaw from the delivery of local anesthetic.

_____Fractures of existing restorations, the tooth, and/or instruments used to perform treatment may occur. Additionally, variations in canal shape and size may complicate treatment and result in a perforation (hole) of the root or root canal filling.

_____I understand that only the root canal treatment is to be done at this office (endodontists are dental specialists uniquely trained to carefully and comfortably treat diseases of the root complex), and I also understand the permanent restoration (filling, crown, post, core or etc.) will be done by my general dentist following root canal therapy.

_____I understand that alternatives to this treatment include extraction or no treatment. Extraction may require replacement with an implant, bridge, or partial denture in order to maintain functional and esthetic requirements. While choosing no treatment is possible, it may result in infection from the roots traveling to other systems with the potential to cause serious problems.

Permission for Root Canal Treatment: I consent to the performance of any dental procedure determined to be necessary in the opinion of the doctor. I agree to ask any questions so I will be clear as to what is necessary to correct the current condition. I understand my other options are no treatment or other dental consultations if desired.

In the event this account should be placed with an outside agency for collection I agree to pay all agency fees, penalties, court costs and attorney fees incurred. I also agree to pay all penalties for returned checks. All information is true and complete.

Signature_____ **Date**_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.)

General Consent for Treatment
I, hereby authorize my doctor to take x-ray(s), photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my determined needs. I understand that x-rays are required for accurate diagnosis, I understand that the use of anesthetic agents embodies a certain risk, and I acknowledge that I have provided a thorough and honest report of my medical history

Signature_____ **Date**_____

Receipt of Treatment Plan and Financial Agreements:

_____ Notice of Privacy Practices: By signing below, I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ Release of Information:To the extent permitted by law, I consent to use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to my practice of the dental benefits otherwise payable to me.

_____ Consent to obtain patient medical history: To the extent permitted by law, I authorize this dental practice (or designee) to collect information about my medical history from my previous health providers.

_____ Consent for case documentation: To the extent permitted by law, I authorize case documentation in the form of intraoral/extra Oral photographs. If published, patient identification will be removed prior to publication.

_____ Some procedures may require a revision which may be an additional cost to the patient.

_____ I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR INDIVIDUAL CHARGES INCURRED DURING THE COURSE OF MY TREATMENT, INCLUDING HOSPITALIZATION, EVEN THOUGH I MAY HAVE INSURANCE OR THIRD-PARTY COVERAGE. I RECOGNIZE THE COST OF THIS CARE MAY EXCEED THE AMOUNT REIMBURSED BY MY INSURANCE COMPANY.

I have read and understand the above policies.

Signature_____ **Date**_____