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Practice Limited to Endodontics

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

## SECTION A: PATIENT GIVING CONSENT

Name:

Address: City:

Telephone: Email:

Patient #:

## SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENT CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protexted health information to carry our treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment payment activities and healthcare operations of the uses and disclosures we may make of your prtected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as describe in our Notice of Privacy Practices. As we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your Protected health information that we mentain.

You may obtain a copy of our Notice of Privacy Practices including any revisions of our Notice at anytime by consulting.

Contact Person:

Telephone: Fax:

Email:

Address:

Right to Revoke: You will have right to revoke this Consent at anytime 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 our revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE:

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative of behalf of the patient, complete the following:

Personal Representative's Name:

Relationship to Patient:

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

Please Print

# REGISTRATION SLIP

Date: _____

Name:

Address:

City: | Zip Code:

Telephone: | Birthday: | ☐ Male ☐ Female

Cellphone: | Does cell phone receive text messaging? ☐ Yes ☐ No

Pharmacy Name and Number:

Social Security No. or ID # for Dental Insurance:

Occupation: | Work Phone:

Employed By:

Employer's Address:

Dental Insurances Co.: | Dental Group #:

Name of Insured: | ID# of Insured:

Date of Birth of Insured:

Employed By:

Employer's Address:

General Dentist Referring you to Our Office:

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 can be guarantee. Occassionally, a tooth which has had root canal therapy may require retreatment, surgery or extraction.

I also understand that only the root canal treatments is to be performed at this office. The permanent (outside) restoration (filling, onlay, crown, etc.) will be done by any regular dentist.

I also understand that the fees vary with the number of canals and the complexity of the treatment. Once quoted, fees remain the same except:

1.) When appointments are cancelled resulting in prolonged treatment.
2.) When appointments are broken without proper notification.
3.) If retreatment or surgery becomes necessary.

I also acknowledge full responsibility for the payment of such services and agree to pay for the in full AT or BEFORE COMPLETION, unless other specific arrangements are made with the office manager. Accounts that are delinquent over thirty days will be charged a finance charge of 1.5% per month. A 35% surcharge will be added to charges referred to a collection agency.

All costs including collection fees, court costs and attorney fees will be insured by the signing party.

Signed: PATIENT, PARENT: _____

# MEDICAL HISTORY

## Medications currently taking (including aspirin, etc.)

| | |
|---|---|
| (1) | (3) |
| (2) | (4) |
| (3) | 5) |

1. Are you currently taking or have you taken any Bisphosphonate Medications (oral or IV Form) these are commonly prescribed for osteoporosis and includebut not limited to such brand names as Fosamax, Actonel, Zonela, Aredia and Boniva. ☐ Yes ☐ No

2. Are you allergic or sensitive to any drug such as penicillin, aspirin, novocaine or codeine? ☐ Yes ☐ No

What?

3. MD's Name: _____

4. Are you subject to fainting, dizziness, nervous disorders, convulsions or epilepsy? ☐ Yes ☐ No

5. Have you ever had any breathing difficulty such as asthma, emphysema, chronic cough, pneumonia, tuberculosis or any lung disorder? ☐ Yes ☐ No

6. Have you ever had any of the following illnesses? If "Yes", Please check:

| | |
|---|---|
| ☐ Heart Trouble | ☐ Kidney Disease |
| ☐ Stroke | ☐ High or Low Blood Pressure |
| ☐ Rheumatic Fever | ☐ Diabetes |
| ☐ Heart Murmur | ☐ Anemia |
| ☐ Mitral Valve Prolapse | ☐ Cancer |
| ☐ Hepatitis or Liver Trouble | ☐ Ulcer |

7. Are you pregnant? (Woman) ☐ Yes ☐ No

8. Are you subject to profuse bleeding? ☐ Yes ☐ No

9. Do you have any artificial joints, heart valves or shunts? ☐ Yes ☐ No

10. Do you routinely take antibiotic premedication before all dental treatment? (For example: Routine Cleaning) ☐ Yes ☐ No

If Yes, what medication do you premedicate with before dental treatment:

_____

11. Do you have a cold, cough or sinus trouble? ☐ Yes ☐ No

12. Other medical problems. ☐ Yes ☐ No

_____

**Submit the Form via Email**