Patient Information

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Patient Information			
Name:	DOB:	Gender: M____ F____ Other___	
Address:			Phone:
Email Address:			SSN: ___-___-____
Emergency Contact			
Name:	Relationship:		Phone:
Insurance Information			
Insurance Provider:	ID #:		Group #:

Medical Health History

Do you have or have you had any of the following? *(Please check any that apply.)*

- Cancer or tumor
- Heart ailment or angina
- Heart murmur, mitral valve prolapse, heart disease
- Rheumatic fever or rheumatic heart disease
- Artificial heart valves
- Artificial joint (approx. date placed: _____)
- High or low blood pressure
- Pacemaker
- Tuberculosis or other lung problems
- Kidney disease
- Hepatitis or other liver disease
- Alcoholism
- Blood transfusion
- Diabetes
- Neurologic condition
- Epilepsy, seizure, or fainting spells
- Emotion condition
- Arthritis
- Herpes or cold sores
- Aids or HIV positive
- Migraine headaches or frequent headaches
- Anemia or blood disorder
- Abnormal bleeding after extractions, surgery, or trauma
- Hay fever or sinus trouble
- Allergies or hives
- Asthma

Do you smoke, vape, or use chewing tobacco?
Yes: _____ No: _____

Are you allergic to, or have you reacted adversely to any of the following?

- Latex materials
- Penicillin or other antibiotics
- Local anesthetics "Novocaine")
- Codeine or other narcotics
- Sulfa drugs
- Barbiturates, sedatives or sleeping pills
- Aspirin
- Other: _____

Are you taking any of the following?

- Aspirin
- Anticoagulants (blood thinners)
- Antibiotics or sulfa drugs
- High blood pressure medication
- Antidepressants or tranquilizers
- Insulin, Orinase, or other diabetes drug
- Nitroglycerin
- Cortisone or other steroids
- Osteoporosis (bone density) medication (Fosamax, Boniva, Zometa, etc.)

Women:

- May be pregnant
  Expected delivery date: _____
- Taking hormones or contraceptives

Other Medications: _____
_____
_____

HIPAA Compliance Patient Consent

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. By signing below, you acknowledge that you have reviewed our notice prior to consenting.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law
- The practice has the right to restrict the use of information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time, and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent

May we discuss your dental conditions/financials with any member of your family?

☐ Yes ☐ No

If **yes**, please name the family members allowed:

Scheduling Appointments

Appointments are reserved specifically for you. We do our best to schedule times that are convenient and allow adequate time for your dental needs.

Please arrive **10 minutes early** to update paperwork and prepare for your visit.

Patients who arrive **more than 10 minutes late** may be asked to reschedule to avoid delaying other patients.

Cancellations and No-Shows

We understand that unexpected situations arise. However, we ask for at least **24 business hours' notice** if you need to cancel or reschedule.

Medicaid Patients

Our office is proud to serve Medicaid patients and appreciates your cooperation in helping us care for all patients efficiently.

Medicaid patients who **fail to provide 24 hours' notice** of cancellation **or do not show up for an appointment** will **not be rescheduled back to the office.**

This policy allows us to prioritize patients who can maintain reliable appointment attendance.

Patient/Legal Guardian Signature: _____ Date: _____

Financial Policy

Payment is due at the time services are rendered.

For your convenience, we accept:
Cash and Checks: A 10% discount is offered for full payment on the day of service with cash or check. This does not apply if we are billing dental insurance.
Cherry: Application assistance is available at the front desk.
CareCredit: Application assistance is available at the front desk.
Discover, Visa, Mastercard, and American Express.

For patients with insurance coverage:
We may accept insurance benefits for your treatment. However, we do require 40% of the cost of treatment to be paid at the time of service. As a courtesy, we will be happy to file your claim for you if you present your dental insurance card. Our practice is committed to providing the best treatment for our patients, and we charge for what is usual and customary for our area.

- The balance is your responsibility, whether your insurance company pays or not.
- We do not bill any secondary insurance.
  We can provide you with all the necessary documentation to be submitted by you.
- We will not pre-verify your insurance coverage or your specific plan's benefits before providing treatment.

Suppose you fail to provide accurate insurance information during treatment. In that case, you will be responsible for paying in full and submitting a claim to your insurance company, acting as your own billing agent to obtain reimbursement.
Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.
We are not a network provider for all insurance plans.
The insurance company's verification of coverage does not guarantee payment.
Note: If your insurance company does not reimburse us after two submissions, you will be responsible for the remainder of the balance.

*I certify that I and/or my dependents have insurance coverage and assign directly to Missoula Endodontics, PC, all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. Missoula Endodontics, PC may use my health-care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining the insurance benefit of the benefits payable service.

COLLECTIONS
Any accounts over 60 days from the time of service will be considered for referral to a collection agency. Civil penalties may apply. In the event of default on payment, I agree to pay any legal interest on the outstanding balance, as well as all third-party fees incurred to rectify the condition of this account or any additional outstanding accounts. A fee of $30 will be charged for all returned checks.
I have thoroughly read the Financial Policy. I understand and agree with this Financial Policy. This policy is in effect for all appointments at our office. Please acknowledge that you have had the opportunity to review this policy by signing below. The undersigned hereby authorizes the release of any information related to all claims for benefits submitted on behalf of myself, spouse, or dependents, including the assignment of benefits pay.

Signature: _____ **Date:** _____

INFORMATION AND ACKNOWLEDGMENT
CONSENT FORM: ROOT CANAL TREATMENT

Endodontic therapy involves the removal of the softer center portion of the tooth, called the pulp, with small metal instruments through an access created in the top portion of the tooth (crown). The space inside the tooth is filled with rubber-like material and cement to seal the root canals. The root(s) of the tooth remain to anchor the tooth in your jawbone. Pulp consists of many components, which include blood vessels and nerve tissue. Cavities, cracks, dental restorations, periodontal disease, and trauma can damage the pulp, thus causing it to degenerate. Endodontic therapy requires from 1 to 3 appointments, depending on the degree of infection/inflammation and the degree of treatment difficulty. The purpose of this treatment is to treat and possibly correct my diseased tooth and/or tissues. I understand there are alternatives to endodontic (root canal) therapy. They include, but are not limited to:

1) No treatment at all. My present oral condition will probably worsen with time, and the risks to my health may include, but are not limited to, pain, swelling, infection, cyst formation, loss of supporting bone around my teeth, and premature loss of tooth/teeth.
2) Extraction with nothing to fill the space. This may result in shifting teeth, a change in bite, and periodontal disease.
3) Extraction followed by a bridge, partial denture, or implant to fill the space.
4) In the case of Retreatment (of previous unsuccessful endodontic therapy), endodontic surgery may also be an option.

I understand that there are certain potential risks and complications in any treatment, including but not limited to:

1) Postoperative discomfort or sensitivity lasting a few hours to several days, which may last longer, with intensity from slight to extreme. Most commonly, the tooth is temporarily sensitive to biting following each appointment, along with slight localized discomfort in the area.
2) Postoperative swelling, infection in the vicinity of the treated tooth, facial swelling, and/or discoloration of tissues, which may persist for several days or longer. Occasionally, a small incision to drain the swelling is required.
3) Restrictive mouth opening (trismus), jaw muscle spasm, jaw muscle cramps, temporomandibular joint difficulty, or change in bite, which occurs infrequently and usually lasts for several days but may last longer.
4) Failure rate of 5-10% under optimal conditions. If failure occurs, additional treatment will be required, such as retreatment, endodontic surgery, or extraction of the affected tooth. Retreatment (of previous unsuccessful endodontic therapy) failure rates are higher but vary due to the suspected reason for failure.
5) With some teeth, conventional endodontic (root canal) therapy alone may not be sufficient, and additional treatment may be required. For example:
a) If the canal(s) are severely bent, calcified/blocked, or split such that they cannot be treated.
b) If an endodontic instrument separates (breaks) in the tooth during treatment.
c) Periodontal disease or problem in which periodontal treatment may be needed.
d) Pre-existing fractures, Substantial infection in the bone, or Perforation of the root, tooth, or sinus. In some cases, follow-up visits may be recommended, while in others, an endodontic surgical procedure, extraction, or other treatment may be required to resolve the problem. The doctor will explain the options available.
6) Restoration Damage, such as Porcelain Fracture, while preparing an opening in the restoration or removing restoration for access to the root canals. If damage occurs, many may be "patched" while others may require replacement of the restoration. Occasionally, restoration may be loosened.
7) Premature tooth loss due to progressive periodontal (gum) disease and/or loosening of the tooth.
8) Complications resulting from the use of instruments, materials, medications, anesthetics, and injections.

I understand that after endodontic therapy, my tooth may require an additional restoration (filling, onlay crown, or bridge). I realize that should I neglect to return to my restorative (family) dentist for the proper restoration within one month that there is an increased risk of 1) failure of the endodontic therapy, 2) fracture of the tooth, and/or 3) premature loss of the tooth.
I understand that I may need to return to this office periodically for a re-evaluation. The purpose of this visit is to monitor the endodontic treatment for healing and recommend further treatment as may be needed. If I do nothing, pain, severe abscess, or disabling infection can result. Teeth treated with endodontic therapy can still decay. As with other teeth, the proper care of these teeth consists of good home care, a sensible diet, and periodic check-ups.
No guarantee of success or perfect result has been given to me. I understand the proposed treatment may not be curative and/or successful to my complete satisfaction. The diagnosis, method, and manner of the proposed procedure(s), the nature and purpose, prognosis, risks of treatment, and feasible alternatives have been explained to me.
I consent to endodontic (root canal) therapy and the administration of local anesthetics. I fully understand this consent form, and it does not encompass the entire discussion regarding the proposed treatment I had with the doctor. I have had the opportunity to question the doctor concerning the nature of treatment, the inherent risks of treatment, and the alternatives to this treatment.

Signature: _____ **Date:** _____