ACCOUNT NUMBER: _____ DATE: _____

PATIENT, PHARMACY & INSURANCE INFORMATION

PATIENT INFORMATION

First Name: _____ Midde: _____ Last Name: _____

Street Address: _____ Zip: _____ City: _____ State: _____

Preferred Phone #: _____ Is this a mobile number: YES NO

Email Address: _____ SS#: _____

Date of Birth: _____ Sex: MALE FEMALE UNSPECIFIED

Emergency Contact: _____ Emergency Phone #: _____

Referring Dentist: _____

RESPONSIBLE PARTY*: **If the patient is a minor or disabled, the Parent/Guardian must sign as Responsible Party*

First Name: _____ Midde: _____ Last Name: _____

Street Address: _____ Zip: _____ City: _____ State: _____

Date of Birth: _____ Sex: MALE FEMALE UNSPECIFIED

Signature of Responsible Party: _____ Date: _____.

PREFERRED PHARMACY:

Name: _____ Phone Number: _____

Street: _____ Zip: _____ City: _____ State: _____

PRIMARY DENTAL INSURANCE:

Is the subscriber the same as the patient? YES NO

Subscriber Information:

First Name: _____ Midde: _____ Last Name: _____

Employer Name: _____ Insurance Company: _____

Insurance Phone #: _____

Subscriber ID/Policy #:_____ Group/Contract #: _____ Date of Birth:_____

Subscriber SS#:_____

Patient Relationship to Subscriber:

☐ Child ☐ Disabled Dependent ☐ Husband ☐ Wife ☐ Self ☐ Other Dependent

SECONDARY DENTAL INSURANCE:

Is the subscriber the same as the patient? YES NO

Subscriber Information:

First Name: _____ Midde: _____ Last Name: _____

Employer Name: _____ Insurance Company: _____

Insurance Phone #: _____

Subscriber ID/Policy #:_____ Group/Contract #: _____ Date of Birth:_____

Subscriber SS#:_____

Patient Relationship to Subscriber:

☐ Child ☐ Disabled Dependent ☐ Husband ☐ Wife ☐ Self ☐ Other Dependent

Pain History

Name: _____ Date_____

Re: Tooth

1. **Are you in pain now? ☐ Yes ☐ No**

2. **Have you experienced pain in this tooth any time in the past? ☐ Yes ☐ No**

3. **Can you locate the tooth that is causing the pain? ☐ Yes ☐ No ☐ Not sure**
   ☐ There may be more than one tooth

4. **Does the pain radiate to other parts of your jaw or down your neck and shoulders? ☐ Yes ☐ No**
   ☐ Not now but has in the past

5. **Is the pain spontaneous or does it always require some stimulus to become painful?**
   ☐ I have spontaneous pain ☐ It always takes some stimulus to make it hurt
   ☐ I don't have spontaneous pain now, but have in the past with this tooth.

6. **Do you feel swollen now? ☐ Yes ☐ No**

7. **Has there been a history of prior swelling? ☐ Yes ☐ No**

8. **Are you running a fever? ☐ Yes ☐ No**

9. **Is the tooth sensitive to temperature? ☐ No, but there is a history of temperature in the past**
   ☐ More to hot than cold ☐ Equally to hot and cold ☐ Neither ☐ Not sure ☐ More sensitive to cold than hot

10. **Has there been any recent restorative work done on this area? ☐ Yes ☐ No ☐ Not sure**

11. **Prior to this appointment has endodontic treatment been started by any doctor? ☐ Yes ☐ No ☐ Not sure**

12. **Have you ever had any endodontic surgery (apico) on this tooth? ☐ Yes ☐ No ☐ Not sure**

DATE: _____

HEALTH HISTORY

Height: _____ ft _____in Weight: _____ lbs Patient Date of Birth: _____

Do you require antibiotics prior to dental procedures? ☐ Yes ☐ No

Are you allergic to or have you had an adverse reaction to any of the following:

☐ **NONE** ☐ Amoxicillin ☐ Aspirin ☐ Codeine ☐ Epinephrine ☐ Latex ☐ Metals ☐ Novocain

☐ Penicillin ☐ Sulfa ☐ Tetracycline ☐ OTHER: _____

List any medications you are taking, including non-prescription drugs and herbals/vitamins:

_____

_____

DENTAL HISTORY:

Date of Last Dental Visit: _____

Have you ever been treated for periodontal (gum) disease? ☐ Yes ☐ No

Have you ever had Novocaine or other local anesthetic? ☐ Yes ☐ No

Please check any conditions that apply to you:

☐ Pain in Jaw (TMJ) ☐ Teeth Grinding/Clenching ☐ Temperature Sensitivity ☐ Mouth Sores

☐ Sensitive Teeth ☐ Broken/Loose Teeth ☐ Difficulty Chewing/Swallow ☐ Swollen/Bleeding Gums

MEDICAL HISTORY:

Are you under the care of a primary physician? ☐ Yes ☐ No

Primary Physician's Name: _____ Phone Number: _____

Date of Last Physical: ☐ I don't know exact date ☐ Last 6 mos ☐ 6 mos- 1 year ☐ 1-3 years

☐ Greater than 4 years ☐ Never ☐ Other: _____

Are you taking or have you taken any steroid/cortisone therapy in the last 2 years? ☐ Yes ☐ No

Have you ever been hospitalized? ☐ Yes ☐ No

Are you taking or have you taken Oral Bisphosphonates (eg FOSOMAX, BONIVA) or IV Bisphosphonates (eg ZOMETA, AREDIA)? ☐ Yes ☐ No How long? _____

Check any conditions that apply to you:

_____None
_____Alcoholism
_____Allergies & Hives
_____Anemia
_____Arthritis
_____Artificial Joint/Pins
Type: _____
Age: _____
_____Aspirin Therapy
_____Asthma
_____Blood Thinners
_____Blood Transfusion
_____Breathing Problem
_____Cancer
Type: _____
_____Chemotherapy
_____Coumadin Therapy
____Dementia
_____Diabetes
Type: _____
_____Dialysis
_____Drug Addiction
_____Epilepsy
_____Excessive Bleeding
_____Fainting/Dizziness
_____Hearing Impairment
_____Heart Murmur
_____Heart Surgery
Date: _____
_____Heart Trouble
Date: _____
_____Hepatitis
Type: _____
_____High Blood Pressure
_____HIV
_____ Kidney Disease
_____Liver Disease
_____Low Blood Pressure
_____Lung Disease/COPD
_____Lupus
_____Mitral Valve Prolapse
_____Mobility Impairment
_____NON-DENTAL Implants
Type: _____
_____Organ Transplants
Type: _____
_____Pace Maker
_____Psychiatric Care
_____Radiation Therapy
_____Radiosurgery _____
_____Rheumatic Fever
_____Seizures
_____Sexually Transmit Disease
_____Sinus Problems
_____ Stomach Problems
_____Stroke
_____Thyroid Disease
_____Tuberculosis (TB)
_____Ulcers
_____Visual Impairment
_____Other Disease/Illness
Type: _____
_____
_____
_____

FEMALE PATIENTS ONLY:

Are you currently pregnant? ☐ Yes ☐ No Estimated Due Date: _____

Are you nursing? ☐ Yes ☐ No Are you taking prescription birth control? ? ☐ Yes ☐ No

*NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician for assistance regarding additional methods of birth control

PATIENT SIGNATURES (HIPAA)

Patient Information:

Name: _____

Preferred Phone: _____

Email: _____

***ARE WE ALLOWED TO LEAVE A DETAILED VOICE OR EMAIL MESSAGE?** YES NO

*** WITH WHOM MAY WE SHARE YOUR PROTECTED HEALTH INFORMATION ("PHI")?** *For Non-Minors: Must specify permission to talk with ANYONE other than patient, including spouse or family members. This includes conversations about scheduling, billing, records.*

NAME: _____

RELATIONSHIP: _____ PHONE: _____

NAME: _____

RELATIONSHIP: _____ PHONE: _____

CONSENT TO SHARE RADIOGRAPHS/CBCT IMAGES

_____ (initial) I authorize the transfer of radiographs and dental records for the referred treatment in the event of transfer to another general dentist or dental specialist. **NOTE:** Photographs, x-rays, and digital images may be used for diagnosis, documentation, reference, teaching, social media, and research publication. In some instances, you may be recognizable in some of these images.

CONSENT TO OBTAIN PATIENT MEDICATION HISTORY

_____ (initial) I authorize Endodontic Specialists of Missouri to collect information about my prescription history from my pharmacy and insurers (as applicable) and give my pharmacy/insurers permission to disclose such information. This includes RX information related to medicines to treat AIDS/HIV and mental health issues.

NOTICE OF PRIVACY PRACTICES

_____ I acknowledge that I have been provided a copy of the HIPAA Privacy Policies, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and posted in the office of Endodontic Specialists of Missouri)

NOTE: We will only use your Protected Health Information ("PHI" for the purpose of treatment, payment, healthcare operations & coordination of care.

SIGNATURE REQUIRED I certify that I have read and understand the above consent requests, and have answered to the best of my knowledge.

X _____ Date: _____

THIS DOCUMENT SHALL EXPIRE ON 12-31-2028

Authorization and Informed Consent for Endodontic Therapy

Please review the following. You will be required to sign it prior to the initiation of treatment; however, it does not commit you to treatment.

I (patient's name) _____hereby authorize Dr. Jaron Wedding and whomever he designates as his assistant (s) to perform endodontic therapy as needed to treat my dental problem or condition. I further authorize the administration of medications and anesthetics, performance of diagnostic procedures, and such additional services that may be deemed reasonable and necessary, understanding that risks are involved. **Insurance often will not cover a CT scan if it is ordered, and the fee is $300.**

Possible alternative methods of treatment may include the following: endodontic surgical procedures, tooth removal, or no treatment, and the advantage or disadvantages of each will be discussed. I understand that I may also choose to decline treatment at this time and understand that the risks in not having treatment include, but are not limited to, pain, swelling, infection, increased bone loss, and eventual tooth loss. I also understand the following:

In general, over 90% of routine cases are successful. Endodontics, as with any branch of medicine or dentistry, is not an exact science. Therefore, no guarantee of treatment success can be given or implied. If the case is not successful, the treatment may have to be redone, a surgical procedure may be required, or the tooth may have to be extracted. In each instance an additional charge will be made. Cases started in other offices or retreatment cases are usually more difficult and may have a different outcome than expected under optimal conditions.

It is usually necessary to alter the tooth structure or remove the restoration (e.g. crown or filling) of the tooth being treated. Proper post-treatment restoration (filling, onlay, crown, etc.) is a necessity. I also understand that only the Root Canal Treatment is to be performed at this office. It is my responsibility to contact my referring dentist soon after completion of the endodontic treatment to arrange for post-treatment restoration.

Treatment will be performed in accordance with accepted methods of clinical practice. Included in the therapy will be the taking of a minimal number of x-rays as directed by the requirement of the case.

Periodic recall examination is often recommended to evaluate the healing after treatment and no further charges are made for it. Compliance, however, is the responsibility of the patient.

Possible complications of treatment include, but are not limited to the following:

a. Procedural difficulties in the course of treatment
b. Swelling, soreness, infection, trismus, numbness, or discoloration of the adjacent soft/hard tissues;
c. Fracture of the crown or root of the tooth or restoration;
d. Fragmentation of the root canal instruments during treatment;
e. Perforation of the root with instruments;
f. Complications following local anesthetic injection (hematoma, paresthesia/anesthesia, allergy, increased heart rate, etc.);
g. Additional unknown or unspecified problems, the explanation for and the responsibility of which cannot be given or assumed.

Should I elect to proceed with treatment recommended, I certify that I have read and understand the above Authorization and Informed Consent Form information and have addressed concerns pertinent to my treatment.

Signature: _____ Date: _____ Patient or Guardian (if patient is a minor)

FINANCIAL POLICY AGREEMENT

We are happy to contact your dental insurance carrier to verify your benefits and coverage, and to provide an ESTIMATE of the amount of treatment cost that your policy will cover.

However, this is ONLY AN ESTIMATE and may vary depending on many factors (ie. recent/subsequent dental procedures at other provider offices, insurance denial of claim, change of treatment plan after initial consult).

Patients are responsible for the COPAYMENT (the difference between the COST OF TREATMENT and the FINAL AMOUNT COVERED BY INSURANCE).

You may receive an additional bill after the date of service if your insurance company does not fully cover the initial estimate.

COPAYMENT IS DUE TODAY, AT THE TIME OF SERVICE. We are happy to work with you to provide payment options (including Care Credit, Cherry and other third party financing options), but a portion of your copayment MUST be rendered and financial arrangements (payment plan) must be secured before leaving the office today.

I understand that, in the event of non-payment, I will be responsible for any collections and legal fees associated with collection of balance due. The collection fee is 25% of the total balance and will be added to the account if it is turned over to an outside collection agency.

I have read the above terms and hereby assume responsibility for paying account charges in full.

Signature of Patient/Guarantor/Responsible Party: _____

(printed name) : _____

Date: _____

**If the patient is a minor or disabled, the Parent/Guardian/Attorney in Fact must sign and complete as Responsible Party*