PATIENT INFORMATION

ACCOUNT NUMBER _____ DATE _____

1 PATIENT INFORMATION

Emergency Contact Information

First Name _____ Middle _____ Last Name _____

Address _____ City _____ State ____ Zip _____

Cell phone _____ Email _____

Date of Birth _____ **Referring Dentist** _____

Emergency Contact _____ Emergency Phone _____

2 RESPONSIBLE PARTY

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

Please check one ☐ Patient ☐ Guardian ☐ Spouse ☐ Father ☐ Mother

Print Name _____

Signature of Responsible Party _____ **Date** _____

3 PREFERRED PHARMACY

If you are unsure, write cross streets and city

Pharmacy Name _____ Phone _____

4 PRIMARY DENTAL INSURANCE

Subscriber Information

Is the subscriber the same as the patient? ☐ Yes ☐ No

First Name _____ Middle _____ Last Name _____

Date of Birth _____ Subscriber SS# _____

Employer _____ Insurance Company _____

Insurance Phone _____ Subscriber ID/Policy _____

Group/Contract _____

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

First Name _____ Middle _____ Last Name _____

Date of Birth _____ Subscriber SS# _____

Employer _____ Insurance Company _____

Insurance Phone _____ Subscriber ID/Policy _____

Group/Contract _____

Patient relationship to subscriber

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

5 PAIN HISTORY

Pain history helps identify the cause and guide proper treatment

CURRENT PAIN

Are you in **pain now**?

☐ Yes ☐ No ☐ Somewhat

Can you **locate the tooth** causing the pain?

☐ Yes ☐ No

Is there **more than one** tooth in pain?

☐ Yes ☐ No

SWELLING AND FEVER

Do you feel **swollen now**?

☐ Yes ☐ No

Do you have a **history** of prior swelling?

☐ Yes ☐ No

Are you running a **fever**?

☐ Yes ☐ No

TEMPERATURE SENSITIVITY

Is the tooth **sensitive** to temperature?

☐ Hot ☐ Cold ☐ None

TREATMENT HISTORY

Has there been any **recent restorative work** done on this area?

☐ Yes ☐ No ☐ Unsure

Prior to this appointment has endodontic **treatment been started** by any doctor?

☐ Yes ☐ No ☐ Unsure

Have you **ever had** any endodontic surgery (apico) on this tooth?

☐ Yes ☐ No ☐ Unsure

PAIN HISTORY AND TRIGGERS

Have you experienced pain in this tooth **any time in the past**?

☐ Yes ☐ No ☐ Unsure

Does the pain **radiate to other parts** of your jaw or down your neck and shoulders?

☐ Yes ☐ No

Is the pain **spontaneous** or does it **always require stimilus** to become painful?

☐ Yes ☐ No

6 HEALTH HISTORY

Health history is to safely plan treatment and avoid complications

Height _____ ft _____ in Weight _____ lbs

Do you require antibiotics prior to dental procedures?

☐ Yes ☐ No

ALLERGIES

☐ None ☐ Amoxicillin ☐ Asprin ☐ Codeine ☐ Epinephrine ☐ Latex

☐ Metals ☐ Novocain ☐ Penicillin ☐ Sulfa ☐ Tetracycline ☐ Acetaminophen

OTHER _____

MEDICATIONS

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 ☐ Unsure

Have you ever had Novocaine or other local anesthetic?

☐ Yes ☐ No ☐ Unsure

Check any conditions that apply to you

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

☐ Sensitive Teeth ☐ Broken/Loose Teeth ☐ Abcess

MEDICAL HISTORY

Are you under the care of a primary physician?

☐ Yes ☐ No

Physician Name _____ Phone Number _____

DATE OF LAST PHYSICAL

☐ Unsure ☐ Last 6 months ☐ 6 months to a year ☐ 1-3 years ☐ Greater than 4 years

☐ Never ☐ Other _____

Are you currently taking steriods/cortisone therapy?

☐ Yes ☐ No

Have you had steroids/cortisone in the past 2 years?

☐ Yes ☐ No ☐ Unsure

Have you ever been hospitalized?

☐ Yes ☐ No

Are you taking or have you taken Oral Bisphosphonates (eg. FOSAMAX, BONIVA) or IV Bisphosphonates (eg. ZOMETAS, AREDIA)

☐ Yes ☐ No For how long? _____

7 CONDITIONS

To avoid complications and ensure safe treatment

*If **nothing** below **applies**, please choose "**NONE**". Otherwise, choose the areas that apply to you.*

- ☐ NONE
- ☐ Alcoholism
- ☐ Allergies & Hives
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joint/Pins
  - Type _____
  - Age _____
- ☐ Asprin 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 Murmer
- ☐ 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 Transplant
  - Type _____
- ☐ Pace Maker
- ☐ Psychiatric Care
- ☐ Radiation Therapy
- ☐ Radiosurgery
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually Transmitted 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 a penicillin) may alter the effectiveness of birth control pills. Consult your physician for assistance regarding additional methods of birth control.*

PATIENT SIGNATURES (HIPPA)

First Name _____ Middle _____ Last Name _____

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")?

MANDATORY FOR NON-MINORS

*All non-minors must **specify permission** to talk with ANYONE other than patient, including spouse or family members. This includes conversations about scheduling, billing, and 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

_____ (initial) 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 and 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. Eckstaine or 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. **Depending on the terms and conditions of your insurance plan, coverage for a CT scan may not be provided. In that event, you may be responsible for a fee of $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/nesthesia, allergy, increased heart rate, etc.);
g. Additional unknown or unspecified problems, the explanation for an 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.

_____ _____ *Patient/Guardian (if patient is a minor)*

Signature Date

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. ***An estimate*** *means* ***a best guess*** *of how much your dental* ***insurance*** *will* ***help pay*** *for the* ***treatment, based on*** *what we find out from* ***your insurance company.***

ESTIMATE FOR SERVICES

This is **ONLY AN ESTIMATE** and the **cost might be different** depending on the following factors

- ☐ Dental work performed at another office before your appointment today
- ☐ Insurance doesn't approve the claim
- ☐ Coverage limits, deductibles, and in-network versus out-of-network status influence out-of-network pocket expenses
- ☐ If your treatment plan changes after we start treatment meaning:
  - *Severe infections require more advanced and extensive, costly procedures*

PATIENT RESPONSIBILITY

- ☐ Patients are responsible for the COPAYMENT *(the* ***difference between*** *the* ***COST OF TREATMENT*** *and the* ***FINAL AMOUNT COVERED BY INSURANCE*** *).*
- ☐ COPAYMENT IS DUE TODAY, AT THE TIME OF SERVICE.
- ☐ You may receive an **additional bill after** the date of service if your insurance company does not fully cover the initial estimate.
- ☐ 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

_____

Print Name

_____

Date

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