Patient Information

First Name_____ Last Name_____

Mailing Address_____

City_____ State/Zip_____

Email Address_____

Birth Date_____ SSN_____ Sex_____

Home #_____ Cell #_____

Employed By_____ Phone #_____

Occupation_____

Referred By_____

Emergency Contact_____ Phone #_____

Legal Guardian_____ Phone #_____

Billing Information

Subscriber Name_____ Birth Date_____ Relationship_____

Insurance Company _____ Employer_____

Identification#_____ Group#_____

WE BILL INSURANCE AS A COURTESY TO YOU.

We will collect your estimated patient portion at the time of your appointment. Keep in mind, insurance companies indicate coverage. Verification does not guarantee payment. As the responsible, you are responsible for any and all balance due. By signing below, you are agreeing to the terms and conditions and are in agreeance to accept full responsibility.

Patient or Responsible Party (print)_____

(signature)_____

Relationship to Patient_____ Date_____

Medical History

1. Have you been under the care of a physician within the past 2 years? If yes, please explain. ◯Yes ◯No

2. Have you been hospitalized within the past 5 years for a serious illness or surgical procedure? ◯Yes ◯No
   If yes, please explain.

3. Are you taking any medications or drugs? If yes, please list them. ◯Yes ◯No

4. Due to medical condition (heart valve replacement, joint prosthesis, ect) are you required to be pre-medicated prior to dental procedures? ◯Yes ◯No
5. Do you take blood thinning medication? (Warfarin, Coumadin, ect) If yes, please explain. ◯Yes ◯No

6. Do you take bisphosphonates (Boniva ect) for osteoporosis or other condition? ◯Yes ◯No
   If yes, please explain.

7. Have you had an allergic reaction to the following?

◯Latex ◯Tylenol ◯Vicodin (hydrocodone) ◯Sulfa ◯Aspirin ◯Codeine ◯Penicillin ◯Ibuprofen ◯Other

8. Do you have any of the following?

◯High blood pressure ◯Heart murmur or MVP ◯Prosthetic heart valve ◯Rheumatic heart disease ◯Heart attack ◯Cardiac pacemaker

◯Heart disease or surgery ◯Blood disorder ◯Hip, knee, or other replacements ◯Tuberculosis ◯Prolonged bleeding ◯Jaundice

◯Stroke ◯Hepatitis ◯Stomach ulcers ◯Colitis ◯Liver disease ◯Sexually transmitted disease ◯ HIV/AIDS

◯Temporomandibular Joint Disease (TMJ) ◯Asthma ◯Emphysema ◯Tobacco use ◯History of drug abuse ◯History of alcohol abuse

◯Sinus trouble ◯Respiratory problems ◯Thyroid problems ◯Kidney problems ◯Diabetes ◯ Radiation therapy ◯Fainting spells or Seizures

◯Epilepsy ◯Psychiatric treatment ◯Cancer

9. Do you have any other disease, conditions, or problems not listed above? Please explain.

Dental History

1. Have you experienced pain in this tooth before?.....◯Yes ◯No
2. You are in pain now, how long have you been in pain?_____
3. Has this pain been keeping you up or waking you in the night?..... ◯Yes ◯No
4. Can you locate the tooth causing you pain?.....◯Yes ◯No
5. Does this pain carry into your jaw, neck, or shoulder?.....◯Yes ◯No
6. Is the pain
   A.) Spontaneous?..... ◯Yes ◯No
   B.) Does it require stimulus to become painful ?.....◯Yes ◯No

7. A.) Do you feel swollen now?.....◯Yes ◯No

   B.) Has there been a history of swelling?.....◯Yes ◯No

   C.) Are you running a fever?.....◯Yes ◯No

8. How would you rate the pain? (1 = Very Slight and 10 = Unbearable)

   ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

9. Do you have lingering pain?.....◯Yes ◯No

10. Describe your pain. _____

11. Is the tooth sensitive to temperature?.....◯Yes ◯No

12. What relieves the pain?_____

13. Has there been restorative work done on this area?.....◯Yes ◯No
14. Have you had any other endodontic treatment on this tooth?.....◯Yes ◯No
15. Are you on any antibiotics?.....◯Yes ◯No
16. Are you taking any pain killers?.....◯Yes ◯No

Endodontic Information and Consent Form

Endodontic (Root Canal) Treatment, Endodontic Surgery, Anesthetics, and Medications. We would like our patients to be informed about the various procedures involved in endodontic treatment and have their consent before starting treatment. Endodontic (root canal) treatment is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by conservative root canal treatment, or, when needed, endodontic surgery. The following discusses possible risks that may occur from endodontic treatment and other treatment choices.

General Risks

Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections. These complications include: swelling; sensitivity; bleeding; pain; infection; numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is transient (temporary) but on infrequent occasions may be permanent; reactions to injections; changes to occlusion(biting); jaw muscle cramps and spasms; temporomandibular (jaw) joint difficulty; loosening of teeth; referred pain to ear, neck, and head; vomiting; allergic reactions; delayed healing; sinus perforations; and treatment failure.

Risks More Specific to Endodontic (Root Canal) Treatment

The risks include the possibility of instruments broken within the canals; perforations (extra openings) of the crown or root of the tooth; damage to bridges, existing fillings, crowns, or porcelain veneers; loss of tooth structure in gaining access to canals; and cracked teeth. During treatment complications may be discovered which make treatment impossible, or which may require dental surgery. These complications may include blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), splits or fractures of teeth.

Medications

Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives, or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effects.

Alternative Treatments

These treatments include no treatment, waiting for more definite development of symptoms, and tooth extractions. Risks involved in the choices might include pain, infection, swelling, loss of teeth, and infection of other areas.

Consent

I, the undersigned, being the patient (parent or guardian of minor patient) consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. I also understand that upon completion of the root canal treatment in this office, I shall return to my general family dentist for a permanent restoration of the tooth involved, such as a crown, cap, jacket, onlay, or filling. I understand that root canal treatment is an attempt to save a tooth which may otherwise require extraction. Although root canal treatment has a high degree of success, it cannot be guaranteed. Occasionally, a tooth which has had root canal treatment may require retreatment, surgery, or even extraction.

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Patient/Parent/Guardian Name (Print) Witness

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.___ for each page, $___ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Patient/Parent/Guardian Name (Print) Witness

High Desert Endodontic Specialists

4101 Caughlin Sq. Ste.#2

Reno, NV. 89519

HIPAA Privacy Release

I understand that according to the Federal HIPAA law that this office is unable to discuss my treatment, account balance or any other matters pertaining to me unless I indicate that they may do so. I agree that the following people can be informed of any association that I may have with this office including, but not limited to treatment, diagnosis, financial agreement, account balances and my general well-being. Also, on my behalf, may request/pick-up my records release.

Please list:

1. _____RELATION-_____

2. _____RELATION-_____

3. _____RELATION-_____

4. _____RELATION-_____

This consent applies until I ask that the name be deleted and a new form replaces this one.

I certify that I have received a copy of the HIPAA Privacy Release provided by High Desert Endodontic Specialists.

PATIENT SIGNATURE: _____ DATE _____

PRACTICE REPRESENTATIVE: _____ DATE _____