Patient Information: (*If patient is under 18, parent/guardian please sign forms*)

Title: Dr. Mr. Mrs. Ms. ☐ Male ☐ Female **Date of Birth: ____/____/_____**

Name: _____
First MI Last Preferred Name

Address: _____,_____
Street City State Zip Code

Telephone #: _____/_____/_____
Home # Cell # Work #

Email Address:_____

SS#: _____-_____-_____
SS# is needed for filling insurance.

Emergency Contact: _____ Phone #:_____

Name of Referring Dentist: _____ Location: _____,_____
City State

Financially Responsible Party (if other than patient):

Name: _____ Relationship to patient: _____
First Last

Address: _____,_____
Street City State Zip Code

Telephone #: _____/_____
Cell# Home #

Primary Dental Insurance:

Policy Holder's Name (if other than patient): Name_____
First Last

Birthdate: ____/____/____ SS#: _____-____-_____ Relationship to patient:_____

Employer: _____ Insurance Co._____

Member ID#: _____ Group#_____

Payer ID#: _____ Insurance Co. Phone #: _____

Secondary Dental Insurance:

Policy Holder's Name (if other than patient): Name_____
First Last

Birthdate: ____/____/____ SS#: _____-____-_____ Relationship to patient:_____

Employer: _____ Insurance Co._____

Member ID#: _____ Group#_____

Payer ID#: _____ Insurance Co. Phone #: _____

Consent for Use and Disclosure of Health Information:

Receipt of Notice of Privacy Practices-Written Acknowledgement Form

Please note that the Notice of Privacy Practices is posted in the office of Brasington Endodontics & Microsurgery, P.A. A copy of this notice is available upon request. In signing below, I acknowledge that I have been made aware of this posted Notice of Privacy Practices.

X_____ Date: _____/_____/_____
Patient/Responsible Party Signature

Medical History- Patient Name:_____ **Date:**_____/_____/_____
First Last

Yes No

☐ ☐ Are you under a physician's care now?
If yes, Dr.'s Name/Practice_____ Phone# _____

☐ ☐ Do you have any type of medical condition that requires you to take antibiotics before dental treatment?

What is your level of anxiety for dental work? ☐ None ☐ Low ☐ Moderate ☐ High ☐ Very High ☐ Extreme

Women: ☐ Nursing ☐ Pregnant/possibly pregnant If yes, expected due date: _____/_____/_____

Do you have or have you ever had any of the following?

Cardiovascular
- ☐ Angina/Chest Pain
- ☐ Congestive Heart Failure
- ☐ Heart Attack/Failure
- ☐ Heart Surgery
- ☐ Heart Trouble/Disease
- ☐ High/Low Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Pacemaker
- ☐ Artificial Heart Valves
- ☐ Heart Malformation
- ☐ Heart Murmur
- ☐ Heart Valve Infection
- ☐ Rheumatic Heart Disease

Endocrine
- ☐ Adrenal Gland Tumor
- ☐ Diabetes
- ☐ Thyroid(Hyper/Hypo)
- ☐ Sjogren's Syndrome

Gastrointestinal
- ☐ Peptic Ulcer Disease
- ☐ GI Disease

Hemotologic
- ☐ Anemia
- ☐ Bleeding(Excessive)
- ☐ Hemophilia
- ☐ Platelet Disorder
- ☐ Sickle Cell Anemia

Hepatic/Renal
- ☐ Dialysis
- ☐ Hepatitis Type_____
- ☐ Liver Disease
- ☐ Kidney Disease

Immune
- ☐ AIDS/HIV
- ☐ Leukemia
- ☐ Systemic Lupus

Muscular Skeletal
- ☐ Arthritis/Gout
- ☐ Artificial Joint(s)
- ☐ Fibromyalgia

Neurologic
- ☐ Seizures
- ☐ Stroke

Psychiatric
- ☐ Chemical Dependency
- ☐ Psychiatric Care

Respiratory
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Emphysema(COPD)
- ☐ Frequent Cough
- ☐ Tuberculosis
- ☐ Sinus Trouble

General
- ☐ Cancer
- ☐ Organ Removal
- ☐ Organ Transplant
- ☐ Radiation Therapy

Are you Allergic to:
- ☐ Anesthetics
- ☐ Codeine
- ☐ Latex
- ☐ Ibuprofen
- ☐ Penicillin
- ☐ Sedatives
- ☐ Tylenol
- ☐ Other:_____

Medications:
Are you taking any of the following? If so, what?
- ☐ Aspirin
- ☐ Antibiotics:
- ☐ Antidepressants:
- ☐ Birth Control Pills

*Antibiotics can reduce the effectiveness of birth control

- ☐ Bisphosphonates (i.e. Fosamax)
- ☐ Blood Pressure Medicine:
- ☐ Blood Thinner:
- ☐ Cortisone/Steroids:
- ☐ Heart Medicine:
- ☐ Hormones:
- ☐ Insulin:
- ☐ Pain Medicine:

Additional Medications:
List below additional medications and reason for taking

_____

_____

_____

_____

_____

_____

_____

Do you have any other medical problems? Discuss: _____

_____

Office Use Only Updated:___/____/_____ Updated:___/____/_____ Updated:___/____/_____ Updated:___/____/____

Financial Information

Welcome to Brasington Endodontics & Microsurgery. Our goal is to provide you with the highest quality endodontic care in a painless and professional manner. We will do everything possible to achieve this goal. In preparing for any dental procedure, we have found that patients appreciate knowing what to expect not only with regard to the procedure but also to fees.

Our current fees are as follows:

Evaluation fee is $90 for the initial quadrant and $60 for each additional quadrant we evaluate. (Due at the time of service for all patients)

Routine non-surgical root canal fees are:

Anterior (front) teeth range from $950 to $1050 for retreatments
Premolars (middle) teeth range from $1050 to $1150 for retreatments
Molars (back) teeth range from $1150 to $1250 for retreatments
Surgical fees are similar in cost to the non-surgical retreatment fees.

Most patients do not require nitrous oxide (laughing gas), however, if you feel it necessary please let us know upon arrival. There is an additional charge of $85 for this option which is normally not covered by insurance.

For patients without insurance, payment is due when the services are rendered. After the insurance claim has been processed, any remaining balance is the patient's responsibility, regardless of the outcome. If you are quoted an estimated insurance payment, **please remember this quote is ONLY an ESTIMATE**. Your insurance company clearly states that there is "NO GUARANTEE OF COVERAGE OR PAYMENT," and **this coverage cannot be determined until the actual insurance claims are processed**. After the insurance claim has been processed, any remaining balance is the patient's responsibility. If you are having an evaluation, the total evaluation fee is due the day of your appointment. If insurance covers this visit, we will reimburse you.

A $30.00 fee will be charged for any returned checks. After 45 days, any unpaid balance will be billed to the patient. Any balance over 60 days will be considered delinquent. In the unfortunate circumstance of a delinquent account, please note that you will be responsible for all collection costs, attorney fees, and court costs. Delinquent accounts will be charged a 1.5% monthly service charge. If you have any questions, please feel free to ask. We will be glad to help you any way that we can.

I understand and agree to the above conditions and hereby authorize the release of information necessary to process my claim. In addition, I authorize payment of my dental benefits directly to Brasington Endodontics & Microsurgery, P.A.

X_____ Date: _____/_____/_____

Patient/Responsible Party Signature

Payment Options Form

Please choose below which payment option preferred:

_____1) Payment in full at time of service. We currently accept cash, check, Visa, Master Card, and Discover.

_____2) Care Credit Financing- Online preauthorization prior to your treatment appointment is required

_____3) Insurance Assignment of Benefit- With this option, we will contact your dental insurance company and attempt to get an estimate from them of what they expect to pay. This can get very complicated and can be inaccurate at times. **This is an estimate of payment and not a guarantee**. At the time of service, the patient's estimated portion is due. The credit card form below is asked to be filled out if there is any remaining balance once insurance pays. No charges will be made prior to contacting you by phone. If the insurance company pays more than expected, then a reimbursement check is mailed to you.

Circle card type: Discover/MasterCard/ Visa Credit/Debit

Card #: _____

Card Expiration Date: _____ CVC (3#'s on back): _____

Card Holder Name: _____

Card Holder Signature: _____

Today's Date: _____

Billing Address: _____

City/State/Zip: _____

Telephone #: _____

I, _____, authorize Brasington Endodontics & Microsurgery, PA to charge the amount due on my account 30 days from the initial date of treatment. Brasington Endodontics & Microsurgery, PA will contact you with the total amount due 24 hours prior to your credit card being charged. Brasington Endodontics, PA reserves the right to charge a service fee for any rejected or NSF transactions.

Office Use Only: Please sign below when an estimate is given

I understand that the fee without insurance for tooth #_____is $_____. With insurance, my *estimated* out of pocket expense is $_____ and that this amount is due at the time of service. I also understand that my insurance will be filed for these services but if my insurance company does not pay what is *estimated* then I am responsible for the remaining balance. If an overpayment is made, it will be refunded to me.

X_____ Date: _____/_____/_____

Patient/Responsible Party Signature

Endodontic Information and Consent Form

Endodontic Root Canal Therapy, Endodontic Surgery, Anesthetics and Medications

We would like our patients to be informed about the various procedures in endodontic therapy and have their consent before starting treatment. Endodontic (root canal) therapy is performed in order to save a tooth which might otherwise need to be removed. Root canal therapy may be completed in one or more appointments. This is accomplished by conservative root canal therapy or, when needed, endodontic surgery. The objectives of this treatment are to relieve pain and infection by cleaning and disinfecting the diseased pulp tissue and filling the root canals so as to preserve the natural tooth. Radiographs and local anesthetics will be required during the treatment. Antibiotics and analgesics may also be needed. The following discusses the possible risks that may occur from endodontic treatment or other treatment choices.

General Dental Procedure Risks: Possible complications of non-surgical and surgical root canal therapy may include but are not limited to the following: soreness, swelling, sensitivity, bleeding, hematoma, bruising, pain, infection, paresthesia (area remains numb which can be temporary but on occasions can be permanent), reaction to injections, gum recession, changes in occlusion (biting), jaw muscle cramps and spasms, temporomandibular (jaw) joint difficulty, referred pain to ear, neck and head, nausea, vomiting, allergic reactions, delayed healing, sinus perforations, and treatment failure.

Risks More Specific to Endodontic Therapy: Risks include the possibility of instruments broken within the root 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 the canals and cracked teeth. During treatment complications may be discovered which make treatment impossible or which may require dental surgery. Such complications may include blocked canals due to fillings or prior treatment, natural calcifications, curved roots, periodontal (gum) disease, and splits or fractures of the teeth. Cases started in other offices or re-treatment cases are usually more difficult and may have a different outcome than expected under normal conditions.

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.

Women Taking Birth Control: Antibiotics such as penicillin, tetracycline, or others, may diminish the effectiveness of birth control medication. For this reason, **additional contraceptive measures are recommended during the time in which any antibiotics are being used.**

Treatment Success: According to more contemporary research, 90-95% of teeth treated by initial root canal therapy will be successful if bone loss has not occurred at the end of the root. Several factors such as previous root canal treatment, fractures, and bone loss at the end of the root can decrease this prognosis. **We will make every effort to help you preserve your natural tooth, however, endodontics, as with any branch of medicine is not an exact science and no guarantee of treatment success can be given or implied.** If a root canal is determined to be unsuccessful, the root canal may be redone, endodontic surgery may be required, or the tooth may have to be extracted at additional fees.

Alternative Treatment Options: Alternative treatment options are available such as choosing no treatment, waiting for the development of more definitive symptoms, endodontic surgery (apicoectomy) or tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infections to other areas. Declining recommended treatment at this time may increase bone loss and/or the future loss of the tooth or teeth in question.

CONSENT

I, the undersigned, being the patient (parent or guardian of above minor patient), acknowledge that I have read this form and consent to the performing of procedures and/or examination decided upon to be necessary or advisable in the opinion of the doctor. I understand that root canal treatment is an attempt to save a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally, a tooth that has had root canal therapy may require re-treatment, surgery or extraction at an additional fee.

If health care workers are accidentally exposed to my blood or other bodily fluids in the course of providing treatment to me, I agree to have my blood tested for any infectious diseases which could have been transmitted to them through this exposure.

I also understand that, upon completion of root canal therapy in this office, I should contact my general dentist immediately to schedule a permanent restoration of the tooth involved. Failure do so in a timely manner has been proven to significantly reduce the chance of root canal success.

_____ **X**_____ Date: _____/_____/_____

Patient's Printed Name Patient/Responsible Party Signature