

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 filing 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: Name _____

Birthdate: ___/___/___ **SS#:** ___-___-_____
First Last **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 _____

Birthdate: ___/___/___ **SS#:** ___-___-_____
First Last **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: _____ **Today's 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
- Sleep Apnea

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 (Bone Density- 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: _____

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.

Please choose below which payment option you prefer:

 1) Full payment of fee at time of service: Payment is due at time of service. We currently accept cash, check, Visa, MasterCard, AMEX, and Discover.

 2) Dental Insurance combined with personal payment: For patients with dental insurance and **as a courtesy**, we will attempt to get an **estimate** from your insurance company and file the dental insurance claims for you. At the time of service, the patient's **estimated** portion is due. **After the insurance claim has been processed, any remaining balance is your responsibility, regardless of dental insurance payment.** If the insurance company pays more than **estimated**, then a reimbursement check is mailed to you. **Insurance estimates are not a guarantee of what they will pay.** Dental insurance companies state in their contracts with you that there is "NO GUARANTEE OF COVERAGE OR PAYMENT," and **this coverage cannot be determined until the actual insurance claims are processed.** **If you have ONLY an evaluation, the total evaluation fee is due the day of your appointment.** If insurance covers any portion of this visit, we reimburse you.

 3) Care Credit Financing: Online preauthorization is required prior to your treatment appointment. The account holder needs to be present at the time of payment. Payment through Care Credit is due at time of service.

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 any collection costs, attorney fees, and court costs. 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

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

I understand the fee without insurance for tooth # _____ is \$ _____. With insurance, my **estimated** out of pocket expense is \$ _____, and this amount is due at the time of service. I also understand that my insurance will be filed; 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 of some of the risks of endodontics before starting treatment. Endodontic treatment is performed to save a tooth which might otherwise need to be removed. Root canal treatment may be completed in one or more appointments. The objectives of this treatment are to relieve pain and infection by cleaning and disinfecting the diseased pulp tissue and filling the root canals 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 potential risks that may occur from endodontic treatment or other treatment choices.

General Dental Procedure Risks: Possible complications of non-surgical and surgical root canal treatment 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 very rarely 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 retreatment cases are usually more difficult and may have a different outcome than expected.

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 treatment will be successful if bone loss has not previously 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 had root canal therapy may require retreatment, surgery or extraction at an additional fee.

If health care workers are accidentally exposed to my blood or other bodily fluids while during 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 return to my general dentist within about two months to schedule a permanent restoration of the tooth involved. Failure do so in a timely manner has been proven to reduce the chance of root canal success.

Patient's Printed Name

X _____
Patient/Responsible Party Signature

Date: ____/____/____