OCEANSIDE ENDODONTICS
St. Augustine

Patient Information (Please Print)

Name _____
First Last Middle Initial (Preferred Name)

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

Birthdate _____ Sex: Male □ Female □

Email _____ Consent to contact via text Yes □ No □

Emergency Contact _____ Phone Number _____

Responsible Party (If under 18 years of age)

Name _____

Address _____

City _____ State _____ Zip _____

Primary Insurance

Policy Holder _____ Birthdate _____

Relationship to Patient □ Self □ Spouse □ Child □ Other SS Number _____

Employer Name _____ Ins. Co. _____

Insurance Address: _____

Policy #: _____ Group #: _____ Insurance Phone #: _____

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MEDICAL HISTORY

Patient Name:_____

NERVOUS SYSTEM
Y / N Frequent headaches
Y / N Numbness or tingling
Y / N Fainting or dizziness
Y / N Epilepsy/Seizures
Y / N Alzheimer's
Y / N Parkinson's
Y / N Stroke
Y / N Other

BONES/JOINTS
Y / N Painful joints (including jaw)
Y / N Arthritis
Y / N Osteoporosis
Y / N Prosthetic joints (Hip, Knee, etc.)

ENDOCRINE SYSTEM
Y / N Diabetes Type I Type II
Y / N Thyroid disease

RESPIRATORY SYSTEM
Y / N Hay fever
Y / N Persistent Cough
Y / N Difficulty breathing
Y / N Asthma
Y / N Tuberculosis
Y / N Emphysema
Y / N COPD

CARDIOVASCULAR SYSTEM
Y / N Congenital heart disease
Y / N Mitral valve prolapse
Y / N High blood pressure
Y / N Congestive heart failure
Y / N Angina (chest pain)
Y / N MI (heart attack)
Y / N Heart surgery (By-pass, etc.)
Y / N Prosthetic heart valves
Y / N Pacemaker
Y / N Defibrillator
Y / N Sickle cell disease
Y / N Bruise or bleed easily
Y / N Hemophilia
Y / N Anemia
Y / N Blood transfusions
Y / N HIV +/AIDS

GI SYSTEMS
Y / N Ulcers (Stomach)
Y / N Hepatitis A B C (Please Circle)
Y / N Cirrhosis
Y / N Kidney problems/stones
Y / N Sexually transmitted disease

OTHER
Y / N Tumors / Growths
Y / N Cancer – Type _____
Y / N Chemotherapy
Y / N Radiation therapy
Y / N Steroid therapy
Y / N Recreational drug use
Y / N Psychiatric treatment
Y / N Drug addiction
Y / N Autoimmune / Immune disorders

Do you drink Alcohol Y / N How often? _____
Do you use tobacco? Y / N How often? _____
Are you on birth control medication? Y / N
Pregnant/Trying to get pregnant? Y / N Nursing? Y / N
Do you have any disease, condition or problem not listed?
Y / N If yes, please explain:
_____

_____

Have you ever taken □ Fosamax □ Boniva □ Actonel or any other medications containing Bisphosphonates?
□ Other _____

DRUG ALLERGIES Y / N

□ Antibiotics _____

□ Anesthetic _____

□ Codeine □ Latex □ Aspirin □ Metal □ Sulfa

□ Other _____

LIST OF CURRENT MEDICATIONS

1. _____
2. _____
3. _____
4. _____
5. _____

(If more space is needed, please write on the back of this page)

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PATIENT INFORMATION

Patient Name _____ Date _____

Who is your General Dentist? _____

DENTAL HISTORY

Reason for today's visit? _____

Rate the level of your pain (1-hardly noticeable, 10-worse pain ever experienced) _____

How long have you experienced this pain? _____

Have you had any recent dental treatment in this area? Y / N

If so, what was done _____

Have you had a root canal on this tooth? Y / N If so, how long ago? _____

What have you taken for the pain? _____ Does it help? Y / N

What is the nature of your pain? (Check all that apply)

_____ Dull ache/throb
_____ Pain is sharp
_____ Pain is constant
_____ Pain is intermittent. When does it hurt? _____
_____ Sensitive to air
_____ Sensitive to sweets
_____ Sensitive to cold _____ cold starts throb _____ pain goes away when cold is removed
_____ Sensitive to heat _____ heat starts throb _____ pain goes away when heat is removed
_____ Pain is spontaneous (Comes on by itself, does not have to be provoked)
_____ Pain is only when provoked (by hot, cold, chewing, etc.)
_____ Pain seems to radiate
_____ Pain keeps me up at night or causes me to wake at night
_____ I have a history of clenching/grinding my teeth
_____ I have pain that seems to be localized around my ear

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Root Canal Therapy Informed Consent

I understand that endodontic therapy (Root Canal Treatment) has been recommended for one or more of my teeth based upon my symptoms, clinical examination, treatment plan that was discussed with me; or I am electively choosing to perform endodontic therapy. I hereby authorize the doctors at Oceanside Endodontics to perform endodontic therapy and administer medication, anesthetics, drugs and perform procedures that she deems necessary or advisable as a corollary to the planned endodontic treatment.

Endodontic therapy is a procedure to retain a tooth that may otherwise require extraction. Endodontic therapy is accomplished by using local anesthetic injections to numb the tooth involved. Access to the pulp chamber (canals) is gained by drilling a hole in the top of the tooth. Endodontic therapy results in the removal of the pulp tissue (nerves and blood vessels) from the inside of the tooth, sterilization of the canals through irrigating solutions and/or medication, then sealing of the canal spaces with a filling material called gutta percha.

Endodontic therapy enjoys a high degree of success, but because it is a biological procedure, success cannot be guaranteed or warranted. Occasionally, a tooth which has had endodontic treatment may require retreatment, periarticular surgery or even extraction. Following treatment the tooth must be restored with a protective restoration by the general dentist. Failure to have the tooth restored in a timely manner after endodontic treatment can result in fracture or loss of the tooth or the necessity to redo the endodontic treatment at an additional fee.

Although complications are rare, there are risks and complications that may occur during or after the procedure including, but not limited to: indefinite anesthesia or numbness from local anesthetic, separated instruments, blocked canals, root perforations, damage to restorations, fracture of the tooth itself, trismus (restricted jaw opening), infection, bleeding and sinus involvement. A patient may experience postoperative discomfort or swelling. In addition, a tooth with a root canal may feel different than other teeth. Some teeth may not be amenable to endodontic treatment. Other treatment choices include no treatment, waiting for more definitive symptoms to develop or tooth extraction. Risks involved in these choices include but are not limited to pain, swelling, loss of tooth, infection and spread of infection to other areas.

The nature of endodontic therapy has been explained to me. I have had the opportunity to have my questions answered to my satisfaction, by the doctor concerning the nature of treatment. I have read this document and understand the information presented.

Patient's Name (Printed): _____

Signature of Patient (Or Legal Guardian): _____ Date: _____

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Additional Informed Consent
For Patients with Crown, Bridge, Onlays or Inlays

As Careful as we are during root canal therapy, there is always the possibility that the crown, bridge, onlay or inlay can be damaged during or after root canal therapy has been rendered. Normally, root canal therapy can be successfully done through a crown, bridge, onlay or inlay without any problems. This is true 95% of the time. However, because we do not know what the status of the natural tooth structure is, the position the crown in in (relative to the natural tooth structure), the potential for decay or fractures, or the thickness of porcelain, there is a possibility that the crown, bridge, onlay or inlay can become damaged during or after treatment. This means the porcelain/gold can be cracked, chipped, broken or dislodged at any time during and/or after root canal therapy. Even after your dentist has properly restored the access opening, the potential for the root fracture, dislodgement or fracture of the crown, bridge, onlay or inlay still exists.

In addition, if necessary, it is possible that the crown, bridge, onlay or inlay may need to be intentionally removed in order to facilitate proper root canal therapy. This becomes more likely if there is decay, fractures or calcified canals. You will be informed if intentional removal of the restoration is needed.

The purpose of this informed consent is to directly inform you that should any damages occur to the crown, bridge, onlay or inlay; you (the patient), accept full responsibility for fabrication of a new restoration.

I fully understand the potential for damage and accept all responsibility for replacing the restoration or crown, should the situation arise

_____ _____

Signature **Date**

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Financial Policy

PAYMENT IS DUE AT THE TIME OF SERVICE

Please Indicate Your Method of Payment:

___ Cash ___ Check ___ Debit Card ___Visa

___ MasterCard ___ Discover ___ American Ex. ___Care Credit

Our Policy Regarding Dental Insurance

We accept Delta Dental, Florida Combined Life, Humana, MetLife Insurance. However, the patient is legally and financially responsible for all costs of dental services regardless of dental insurance coverage. If the insurance does not pay within 60 days of the date the claim was filed, the account becomes due and payable by the patient. If the insurance company denies a claim, the patient is ultimately financially responsible for any services rendered.

Estimates: We will give an **ESTIMATE** of the patient's copayment. This is ONLY an ESTIMATE based on limited information provided by the insurance company. You could owe more than the estimated portion depending on your remaining benefits and coverage limitations. Any amounts overpaid will be mailed to the patient's address on file via check.

Please remember, the financial obligation for dental treatment is between you and this office. It is not between this office and your insurance company.

If Root Canal Therapy is initiated and the tooth is fractured, compromised or not salvageable, you will not be charged for the full root canal treatment. ***There will be an estimated fee of $595 for the services provided, which may or may not be covered by your insurance.***

In some cases to provide an accurate diagnosis, a **CBCT Scan** may be taken. The fee for the scan is $175 and typically not covered by insurance.

Overdue Fees

We reserve the right to charge interest on any unpaid balances over 90 days in the amount of 18% APR, as provided by state law. Should your account be turned over to a collection agency, all costs to collect overdue fees as allowed by law will be your responsibility, including collection cost and/or attorney fees.

I have read the Financial Policy outlined above. I understand and agree to the policies herein.

Signature: _____ Date: _____

Signature of Patient or Legal Guardian

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HIPAA Consent for Use and Disclosure of Health Information and Release Form

PATIENT INFORMATION

Patient's Name _____ DOB _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Our practice has always safeguarded and protected our valued patient's personal and health information. These safeguards meet or exceed the 2003 HIPPA (Health Insurance Portability and Accountability Act), under the Department of Health and Human Services requirements to include the September 2013 *Omnibus* updated privacy regulations.

Our practice privacy policies, in accordance, allows us to use your personal information for "normal and customary" services when required communication within the healthcare profession, both clinical and administrative, to include but not limited to: consultations with another healthcare professional such as your medical doctor or another dental specialist about your treatment and progress, assisting with patient insurance, appointment reminders, account financial information and laboratory cases.

I, _____, have read reviewed and considered the contents of the consent form and was given a copy of the practice's "Notice of Privacy Practices".

I understand, that by signing this Consent form, I am giving my legal consent for your disclosure and use of mine and/or my dependent's (minor child or other person(s) whom I am the legal guardian of) protected private personal and health information in any form deemed needed in the practice's professional judgement and in accordance with your normal and customary privacy and security practices.

I have the legal right to amend or revoke this Consent given at any time by providing your practice with a written and signed notice.

Our practice retains the right to decline treatment would you choose not to sign this Consent, should you choose to revoke it, or should you have what we would consider unreasonable exemptions.

_____ _____

Signature ***Date***

_____ _____

Signature of Personal Representative ***Date***

_____

Please Print Name of Representative

☐ **Request for Exemption: Mark this box if you wish for any of your information <u>NOT</u> to be used for normal and customary practices within the healthcare profession. Specifically write / mark your request for exemption(s) or limitation(s) below. Specify the person(s) you <u>DO NOT</u> want your information released to.**