PINE LAKES
ENDODONTICS

PATIENT INFORMATION

Patient Name ______________________ Date of Birth ______________

Person Responsible For Account ______________________ Relationship to Patient ______________

Address ______________ City ______________ State ________ Zip ______________

Phone Numbers: Home ______________ Cell ______________ Work ______________

Preferred Phone Contact (Please Circle) Home Cell Work Social Security # ______________

Employer ______________________ Occupation ______________

Referring Dentist ______________________ City ______________

Emergency Contact Name ______________________ Phone ______________

PRIMARY INSURANCE INFORMATION

Person Responsible or Policy Holder ______________________ Relationship to Patient ______________

Insured's Date of Birth ______________ Dental Insurance Provider ______________

Group # ______________ ID #/SSN ______________

Address ______________ City ______________ State ________ Zip ______________

Phone ______________ Employer ______________

SECONDARY INSURANCE INFORMATION

Person Responsible or Policy Holder ______________________ Relationship to Patient ______________

Insured's Date of Birth ______________ Dental Insurance Provider ______________

Group # ______________ ID #/SSN ______________

Address ______________ City ______________ State ________ Zip ______________

Phone ______________ Employer ______________

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We never want you to be surprised by the cost of your treatment. Please verify the approximate cost of your treatment prior to being seen. You will be responsible for payment at the time of treatment. We accept cash, check, Visa, Mastercard, Discover, and American Express. CareCredit may be an option for you as well. Please ask our patient coordinators for further information if you are interested.

For patients with insurance coverage, copayment is due at the time of treatment. We are happy to assist you in filing your dental insurance claim. We will give you the best estimate we are able to determine from your insurance provider; however, **please understand that our calculations are strictly ESTIMATES and there is no guarantee that your insurance company will reimburse us according to these estimates.** Your insurance policy is a contract between you and your insurance company, and we are not a party to that contract. You are responsible for any portion of the treatment fee that your insurance company does not pay, for any reason.

A finance charge is computed at a periodic rate of 1.5% monthly (annual percentage rate of 18%) on any unpaid balance over 90 days. A fee of $35 will be charged for all returned checks. Any attorney or collection fees incurred due to delinquency in payment will also be charged to the patient.

I have read the Financial Policy and understand my financial responsibility for dental services provided. I hereby authorize payment of the dental insurance benefits otherwise payable to me directly to **Pine Lakes Endodontics** and authorize release of any information relating to a claim.

Patient Signature ______________________ Date ______________

MEDICAL HISTORY

Patient name (print) ______________________________ Date of birth ______________

Name of your regular physician or medical clinic ______________________________

Whom may we notify in case of an emergency? Name ______________________________

Phone # ______________________________

Relationship to you ______________________________

1. Has there been any change in your general health within the past year? Yes No
2. Are you now under the care of a physician? Yes No

   If yes, what is the condition(s) being treated? ______________________________

   ____
3. Has your doctor instructed you to take antibiotics before dental treatment? Yes No

   If yes, for what reason? Ex: Joint Replacement, etc. ______________________________
4. Are you pregnant (WOMEN)? Yes No

   If yes, when is the due date? ______________________________
5. Have you had abnormal bleeding associated with previous surgery? Yes No
6. Have you taken any prescription medications or infusions for increased bone density (Fosamax, Boniva, Actonel, Prolia, etc)? Yes No
7. Have you ever received any head/neck radiation treatments? Yes No
8. Do you smoke or use tobacco products? Yes No
9. Do you or have you ever had problems with alcohol/chemical abuse/dependency? Yes No
10. Do you have an allergy or sensitivity to latex? Yes No
11. Do you have a strong anxiety towards dental treatment? Yes No
12. In addition to local anesthetic, are you interested in using nitrous oxide? Yes No
13. Do you have a history of any of the following? (please check all that apply)

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart attack
- ☐ Stroke
- ☐ Blood disorder (anemia)
- ☐ Chest pain (angina)
- ☐ Congestive heart failure
- ☐ Artificial heart valve
- ☐ Artificial joint
- ☐ Diabetes, low blood sugar
- ☐ Hepatitis, liver disease
- ☐ HIV/AIDS
- ☐ Asthma
- ☐ Syncope (fainting)
- ☐ COPD (emphysema/chronic bronchitis)
- ☐ Tuberculosis
- ☐ Sinus trouble
- ☐ Thyroid problems
- ☐ Stomach ulcers, colitis
- ☐ Cancer
- ☐ Seizures, epilepsy
- ☐ Dialysis, kidney trouble
- ☐ Anxiety, depression
- ☐ Osteoporosis
- ☐ Bell's palsy, facial numbness/pain
- ☐ Temporomandibular joint problems (TMJ/TMD)
- ☐ Atrial Fibrillation (A-Fib)
- ☐ IF NONE APPLY, CHECK HERE

14. Do you have any disease, condition, or problem not listed above? Yes No

    If yes, what is it? ______________________________
15. Please LIST ALL OF YOUR ALLERGIES or sensitivities (substances, medications, etc)______________________________

    ____
16. Preferred Pharmacy & Location ______________________________

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING (OR WE CAN SCAN YOUR LIST): ______________________________

____

Patient/Guardian signature______________________________ Date ______________

Consent for Use & Disclosure of Health Information

I pledge I have read/received a copy of this practice's Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Name (Please Print):______________________________Date of Birth:_____________

Signature:____Date:_____________

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:____

Relationship to Patient:____

Additional Release of Information:
I authorize the additional release of information including the diagnosis, records, treatment rendered to me, and claims information. The information may be released to:

[ ] Spouse/Partner:____

[ ] Children:____

[ ] Other:____

[ ] DO NOT RELEASE TO ANYONE ELSE

Messages:
Please call:

[ ] My Home

[ ] My Cell

[ ] Other:____

If I am unable to be reached, you may:

[ ] Leave a detailed message

[ ] Leave a message asking me to return your call

Revocation of Consent:
I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written Notice of Revocation. I also understand that you may decline to treat me after I have revoked my consent.

Signature:____Date:_____________

Record of Discussion and Informed Consent for CBCT

A CBCT scan (also called cone beam computerized tomography) is an x-ray technique that is similar to a medical CT scan. It produces images of your body that depict internal structures in cross-section rather than the overlapping images typically produced by conventional dental x-ray exams.

A conventional x-ray of your mouth limits your dentist to a two-dimensional (2D) view. Diagnosis and treatment planning can require a more complete understanding of the complex three-dimensional (3D) anatomy of your tooth. A CBCT scan can provide this crucial 3D information to accurately diagnose and treat conditions which may not be fully understood otherwise.

Risks: CBCT scans, like other dental x-rays, expose you to a very small amount of radiation. The dose is approximately the same as the following background radiation equivalents: 1 day for upper teeth, 3 days for lower front teeth and 5 days for lower back teeth. The alternative to a CBCT scan is a conventional dental x-ray; however, this has the limitations previously noted.

While parts of your anatomy beyond your mouth and jaw may be seen on the scan, your dentist is not a physician or specialist to make assessments concerning the anatomy beyond your mouth or jaw. If the scan raises a question as to something unusual outside the mouth or jaw, your dentist may refer you to a physician or another specialist for evaluation. In such an event, our office can place the image on a DVD. CBCT images do not show most soft tissues or fluids, so some problem areas may have to be imaged with other methods.

Women: CBCT scans are not recommended for routine use on pregnant women due to the potential danger to the fetus. Please initial below as appropriate:

______ I am not pregnant

______ I am pregnant

______ I am unsure if I am pregnant

The CBCT scan is not included as part of my examination/consultation, and I understand that there is an additional fee. This can be billed to my insurance, if applicable, but there is no guarantee that it will be a covered service.

I certify that I have read this consent form and understand the imaging to be performed, as well as the risks, benefits and alternatives. I acknowledge that I have had the opportunity to discuss this procedure and have had all questions answered to my satisfaction. I consent to a CBCT scan to aid in diagnosis and/or treatment.

Patient signature ____ Date ____________________

Print name ____