PATIENT REGISTRATION AND MEDICAL HISTORY

| Phone: Home | Work | Cell | (Best Number to Call) | |
|-----------------------------|--|--|-----------------------|---|
| E-Mail | | | | |
| Patient | First name | | | |
| Last name | First name | Middle Initial | | Nick Name |
| Mailing Address | | City | State | Zip Code |
| this service. If you do no | BirthdateS number is so we may verify and ot wish to provide us with your ile your own dental insurance | Social Security # file your dental insurance. We social security number then y | Vithout it we a | The reason we ask are unable to provide to pay your fee in full a |
| Employer | Oc | ecupation | | |
| Who may we thank for r | eferring you? | | | |
| In case of emergency, w | e of emergency, who should be notified?Phone | | | |
| Have you ever had any o | of the following? (CHECK BOX | (ES THAT APPLY) | | |
| □Heart Murmur | □Stroke | □Sinus trouble | | |
| □Diabetes | □Tuberculosis | □Asthma | | |
| □Cancer | □Thyroid Problems | □Fainting spells | | |
| □Seizures | □A.I.D.S./H.I.V. | □High blood pressure | | |
| □Arthritis | □Pacemaker | □Low blood pressure | | |
| □General Allergies | □Hepatitis | □Artificial knee, hip o | or joint | |
| □Artificial Heart Valves | □Mitral valve Prolapse | □Epilepsy | | |
| □Swollen neck glands | □Rheumatic Fever | □Anxiety or panic atta | acks | |
| □Sexually transmitted disea | ase Immune Problems | □Kidney trouble | | |
| □Ulcers | □Cardiovascular disease | □Respiratory problem | ıs | |
| • | □Chemical Dependency | | | |
| | | | _ | |
| Are you allergic or have | e you had a reaction to: | | | |
| □Local anesthetics | □Penicillin | □Other | | |
| • | □Codeine | | | |
| □Iodine | □Sulfa | | | |
| If you are taking any me | dicine including non-prescription | on medicine, please list. | | |
| surgery or other known i | is for patients with heart murmureasons that an antibiotic is need hat you should be pre-medicate | ded before dental treatment ar | nd that you ha | |
| (Women) | | | | |
| Are you pregnant? - yes | s □ no Are you nursing? □ y | es no Are you taking b | irth control pi | lls? □ yes □ no |
| Signature | | Date | | |

| ASSIGNMENT | T AND RELEASE (For patients with Dental Insuranc | 2) |
|---|---|--|
| I, the undersign | ed, have insurance with | and assign benefits |
| my insurance omy claim base CLAIMS IS A | anced Endodontics. I understand that my co-payment is carrier. THIS IS NOT A GUARANTEE OF PAYMENTED OF the provisions of my policy and the current in | s an <u>ESTIMATE</u> based on the information provided by <u>BY MY INSURANCE CARRIER</u> . My carrier will process formation from my employer. <u>FILING INSURANCE</u> IN NO WAY RELIEVES ME OF RESPONSIBILITY FOR |
| <u>WIY BILL. I Al</u> | MAWARE THAT I AM RESPONSIBLE FOR ANY A | MOUNT NOT COVERED BY MY CARRIER. |
| Date | Signature of Insured | Consent For Minor |
| MINOR/CHI | LD CONSENT | |
| authorize the cadministration appointment w | rent or guardian of | |
| | | |
| FINANCIAL S | statement (All patients must sign) | |
| I acknowledge | e that payment is due at the time of treatment. I acc | ept full financial responsibility for all charges. |
| Signature | Date | |
| | | |
| E-MAIL AUT | THORIZATION | |
| | ion to Advanced Endodontics LLC to email (unenc NOT be altered if I do not give email authorization | rypted) x-rays that may be taken back to my dentist. My |
| Signature | Da | e |
| | DATIENT ACKNOWI EDG | SEMENTS |
| correc care ir | et to the best of my knowledge. I understand the abo | ny additional information that I may furnish is true and ove information is necessary to provide me with dental odis/Dr. Clark, or the staff responsible for any errors or |
| Signature_ | | Date |

Authorization and Informed Consent for Endodontic Therapy and Medications

I hereby authorize Dr. Goodis/ Dr. Clark, to perform Endodontic therapy and allow whomever he may designate to be his assistant.

I further authorize the administration of medications and anesthetics, performance of diagnostic procedures and such services that may be deemed reasonable and necessary.

Possible alternative methods of treatment may include surgical procedures, tooth removal, placing an implant, partial denture, or fixed bridge. I realize that I may also choose to decline treatment at this time. I understand the risks in not having treatment include, but are not limited to: pain, swelling, infection, increased bone loss or loss of the tooth.

I also understand the following:

As a rule, 90-95% of routine cases are successful. No guarantee of treatment success can be given or implied. I understand that many factors contribute to the success of root canal treatment which cannot be determined in advance. Therefore, in some cases treatment may have to be discontinued before it is completed, or may fail following treatment. Some of these factors are of the following: my resistance to infection, the location and shape of the canals, cracked root, poor periodontal health of the tooth, or not having the tooth promptly restored by my (a) general dentist (for example not having a crown placed on the tooth when indicated after having root canal treatment).

- 1. If treatment is not successful, surgery (Apicoectomy) or extraction of the tooth may be required at an additional cost.
- 2. Cases started in other offices or re-treatment cases are usually more difficult and may have a different outcome than expected under optimal conditions.
- 3. It may be necessary to alter the tooth structure or remove the filling or crown from the tooth being treated.
- 4. Some cases may require a second or multiple visits to complete Endodontic Treatment.
- 5. Possible complications of treatment include, but are not limited to the following:
 - a) swelling, soreness, infection, trismus (difficulty in opening the mouth) or discoloration of the adjacent soft tissues.
 - b) fragmentation of Biocompatible instruments inside the root. (Rarely occurs)
 - c) perforation of the root. (Rarely occurs)
 - d) complications following anesthesia (bruising, swelling, allergy, increased heart rate, etc.).
- 6. Proper post-treatment restoration (filling, onlay, crown, etc.) is a necessity. I must contact my referring dentist soon after completion of the Endodontics to arrange for this. I understand that my general dentist will charge me an additional fee for this procedure.

 Treatment will be performed in accordance with accepted methods of practice. Included in the therapy will be the taking of x-ray films (4-6) as dictated by the courses of treatment.

| I certify that I have fully read and understand the above authorization and informed consent. | | | | | |
|---|---|---|--|--|--|
| Date: | / | / | Signature of patient or legal guardian | | |

contacting:

7520 Montgomery Blvd NE Suite E-1 Albuquerque, NM 87114 (505)-797-1212 (505)-823-1831

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

| PATIENT NAME | DATE | | | |
|--|---|--|--|--|
| I understand that under the Health Insurance Portability and Accordation Rights regarding my protected health information. | ountability Act of 1996 (HIPAA), I have certain | | | |
| nderstand that Advanced Endodontics LLC may use or disclose my protected health information for atment, payment or health care operations—which means for providing health care to me, the patient; and billing and payment; and, taking care of other health care operations. Unless required by law, there be no other uses and disclosures of this information without my authorization. | | | | |
| Advanced Endodontics LLC has a detailed document called the ' Notice of Privacy Practices '. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information. | | | | |
| I understand that I have the right to read the 'Notice' before signification of the Endodntics LLC will provide me with the most current Notice of Pr | - | | | |
| My signature below indicates that I have been given the chance to review such copy of the <i>Notice of Privacy Practices</i> . My signature means that I agree to allow Advanced Endodontics LLC to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Advanced Endodontics LLC has taken action relying on this consent. | | | | |
| | | | | |
| SIGNATURE (Patient or Legal Custodian/Authorized Representative) | DATE | | | |
| | | | | |
| Relationship to Patient if signed by another party | DATE | | | |
| | | | | |

Advanced Endodontics LLC, 7520 Montgomery Blvd NE Suite E-1, Albuquerque, NM 87109, (505)-797-1212.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our 'Notice' at any time by