PATIENT REGISTRATION AND MEDICAL HISTORY

Phone: Home _____Work_____Cell_____(Best Number to Call)_____

E-Mail_____

Patient_____
Last name First name Middle Initial Nick Name

Mailing Address_____City_____State_____Zip Code_____

Sex: ▫M ▫F Age_____ Birthdate_____ Social Security #_____The reason we ask for your social security number is so we may verify and file your dental insurance. Without it we are unable to provide this service. If you do not wish to provide us with your social security number then you will have to pay your fee in full at the time of service and file your own dental insurance.

Employer_____Occupation_____

Who may we thank for referring you? _____

In case of emergency, who should be notified? _____Phone_____

Have you ever had any of the following? (**CHECK BOXES 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 or joint
▫Artificial Heart Valves	▫Mitral valve Prolapse	▫Epilepsy
▫Swollen neck glands	▫Rheumatic Fever	▫Anxiety or panic attacks
▫Sexually transmitted disease	▫Immune Problems	▫Kidney trouble
▫Ulcers	▫Cardiovascular disease	▫Respiratory problems
▫Psychiatric Care	▫Chemical Dependency	▫Anemia

▫other_____

Are you allergic or have you had a reaction to:

▫Local anesthetics	▫Penicillin	▫Other _____
▫Aspirin	▫Codeine	
▫Iodine	▫Sulfa	

If you are taking any medicine including non-prescription medicine, please list.
_____

_____
The following question is for patients with heart murmurs, rheumatic heart disease, joint replacements, artificial plastic surgery or other known reasons that an antibiotic is needed before dental treatment and that you have been advised by your treating physician that you should be pre-medicated. **Are you pre-medicated?** ▫yes ▫no

(Women)
Are you pregnant? ▫ yes ▫ no Are you nursing? ▫ yes ▫ no Are you taking birth control pills? ▫ yes ▫ no

Signature_____ **Date**_____

ASSIGNMENT AND RELEASE ***(For patients with Dental Insurance)***

I, the undersigned, have insurance with _____ and assign benefits
Name of insurance company
Directly to Advanced Endodontics. I understand that my co-payment is an **ESTIMATE** based on the information provided by my insurance carrier. THIS IS NOT A GUARANTEE OF PAYMENT BY MY INSURANCE CARRIER. My carrier will process my claim based on the provisions of my policy and the current information from my employer. **FILING INSURANCE CLAIMS IS A SERVICE PROVIDED WITHOUT CHARGE AND IN NO WAY RELIEVES ME OF RESPONSIBILITY FOR MY BILL. I AM AWARE THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY CARRIER.**

_____ _____ _____
Date **Signature of Insured** **Consent For Minor**

MINOR/CHILD CONSENT

I being the parent or guardian of_____ do hereby request and authorize the dental staff to perform necessary dental services for my child including but not limited to X-rays and administration of anesthetics which are deemed advisable by the doctor whether or not I am present at the actual appointment when the treatment is rendered. I agree that parents/guardian is responsible for all fees and services rendered for treatment of a minor/child.

FINANCIAL STATEMENT ***(All patients must sign)***

I acknowledge that payment is due at the time of treatment. I accept full financial responsibility for all charges.

Signature _____ Date _____

E-MAIL AUTHORIZATION

I give permission to Advanced Endodontics LLC to email (unencrypted) x-rays that may be taken back to my dentist. My treatment will NOT be altered if I do not give email authorization.

Signature _____ Date _____

PATIENT ACKNOWLEDGEMENTS

- I affirm that the information contained in this form and any additional information that I may furnish is true and correct to the best of my knowledge. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I will not hold Dr. Goodis/Dr. Clark, or the staff responsible for any errors or omissions that I have made in the completion of this form.

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_____

Advanced Endodontics LLC

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 Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Advanced Endodontics LLC may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will 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 signing this agreement. If I ask, Advanced Endodntics LLC will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. 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**

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

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