Frederick Endodontics, LLC
198 Thomas Johnson Drive, Suite 11
Frederick, MD 21702

Patient Information

Patient Name: _____ Date: _____
Last, First Middle (Preferred Name)

Address: _____
Street Apartment #

_____
City State Zip Code

Phone #: (C) _____ (W) _____ ext: _____ (H) _____

Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Widow ☐ Divorced ☐ Child

Social Security #: _____ Birth Date: _____

Employer Name: _____ Occupation: _____

General Dentist: _____ Referred by: _____

Emergency contact: _____ Phone #: _____

For Minor Patients: Responsible Party Information

Name: _____ Relationship to Patient: _____
Last, First MI

Address: _____
Street City State Zip Code

Social Security #: _____Birth Date: _____

Phone #: _____☐ cell ☐ work ☐ home

Insurance Information

Dental Insurance Company: _____

ID #: _____ Group #: _____ Policyholder Employer: _____

Policyholder: Name: _____
Last, First MI

Address: _____
Street City State Zip Code

Social Security #: _____ Birth Date: _____

Patient's relationship to policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Dependent

Insurance Assignment and Release

I assign insurance benefits, if any, otherwise payable to me for services rendered, directly to the dental office. I understand that I am financially responsible for all charges, regardless of whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

I authorize the release of my health care information and disclosure of such information to the insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

X_____ _____
Signature of Patient or Responsible Party Print name of Patient or Responsible Party

_____ _____
Date Relationship to Patient

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Health History

Name of Physician: ______________________________ Phone: ____________________

Are you currently being treated for any conditions/illness? ☐ No ☐ Yes ______________________

Medications: ____

____

ALLERGIES: ☐ **NONE** ☐ **LATEX** ☐ **Medications?** List ______________________________

Women: Are you pregnant? ☐ No ☐ Yes, no. of wks. __________

Please check yes or no to indicate if you have ever had any of the following. If yes, please explain below.

	No	Yes		No	Yes		No	Yes		No	Yes
AIDS/HIV	☐	☐	Epilepsy	☐	☐	Hepatitis/Liver Disease	☐	☐	Radiation/Chemotherapy	☐	☐
Artificial Joints	☐	☐	Dizziness/Fainting	☐	☐	High/Low Blood Pressure	☐	☐	Respiratory Problem	☐	☐
Asthma	☐	☐	Excessive Bleeding	☐	☐	Kidney Disease	☐	☐	Sinus Problems	☐	☐
Blood Disorder	☐	☐	Head Injuries	☐	☐	Lung Disease/Tuberculosis	☐	☐	Stroke	☐	☐
Cancer/Tumors	☐	☐	Heart Disease	☐	☐	Nervous Disorders	☐	☐	Thyroid Condition	☐	☐
Diabetes	☐	☐	**Heart Murmur**	☐	☐	Pacemaker/Artificial Valve	☐	☐	Ulcers/Colitis	☐	☐

Do you have additional medical information or health issues not indicated above, or that need further clarification?
☐ No ☐ Yes Comments:____

I certify that the above information is true and correct. It is my responsibility to inform the dentist immediately should there be any changes to the information above.

X______________________________ ______________

Signature of Patient or Responsible Party Date

(Office use only) **

Reviewed by: ________________________ Comments: ______________________________

Signature of Dentist Date

HR: _____ BP: ______________________________

Conditions of Treatment / Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. An estimate of your financial responsibility will be provided to you prior to treatment. Any estimated insurance benefits, if applicable, are provided as a courtesy and are not guarantees of any insurance payment or coverage. This is an estimate and any changes to your treatment, or unanticipated complexities arising during treatment, may change the estimate.

All emergency dental services, or dental services performed without prior financial arrangements, must be paid in full at the time of service. For your convenience, we accept MasterCard, Visa, Discover, American Express, CareCredit, and cash.

<u>If we are NOT a participating provider with your dental insurance plan</u>, you will be responsible for all treatment charges at the time of service. As a courtesy, if you provide current and complete insurance information at the time of service, our office will submit a dental claim for your direct reimbursement.

<u>If we are a participating provider with your dental insurance plan</u>, you will be responsible for payment in full of all deductibles, co-pays, and charges for non-covered services at the time services are rendered. If an overpayment occurs, a refund check for the overpayment will be mailed to you.

A late fee of $39 and interest charges of 1.5% per month (18% annually) will be charged on any account balance exceeding 60 days. Account balances exceeding 90 days will be referred for collection activity and subject to additional administrative, collection and legal fees. Any previous courtesies extended will be retracted. A $35 fee will be charged for any check returned as unpaid. A broken appointment fee of $150 will be charged for missed appointments or appointments cancelled with less than 48 hours notice.

My signature below indicates that I have read, understand, and agree to the above conditions of treatment and financial policy, and I accept full responsibility for all charges.

X______________________________ ____________ ________________

Signature of Patient or Responsible Party Date Relationship to Patient

Frederick Endodontics, LLC
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301-682-8181

ENDODONTIC CONSENT

We like for our patients to be informed about the various procedures involved in endodontic therapy and have their consent before beginning treatment. Endodontic therapy is performed in order to save a tooth that might otherwise need to be removed. This is accomplished by root canal therapy, a treatment in which the chambers within the roots of the tooth are cleaned out and filled, or when needed, endodontic surgery. The following discusses the possible conditions and risks that may occur during or following endodontic therapy or other treatment choices.

Risks: Risks include, but are not limited to, sensitivity, pain, swelling, infection, bleeding, numbness and tingling sensation to lips, tongue, chin, gums, cheeks, and teeth, which is transient, but on infrequent occasions may be permanent, reaction to injections, changes in occlusion, jaw muscle cramps or spasms, TMJ (jaw joint) difficulty, loosening of teeth, referred pain to ear, head and neck, delayed healing, and sinus perforation.

Risks More Specific To Endodontic Therapy: Risks include instrument separation, perforation of the crown or root of the tooth, damage to crowns, bridges, veneers, fillings, loss of tooth structure in gaining access to canals, and cracked teeth. During treatment complications may be discovered which make treatment impossible, or which may require dental surgery. These complications may include blocked canals due to fillings or prior treatment, natural calcifications, separated instruments, curved roots, periodontal disease, and splits or fractures of the teeth.

Other Treatment Choices: These include no treatment, waiting for more definite development of symptoms, or tooth extraction. Risks involved in these choices include pain, swelling, infection, loss of teeth, and infection to other areas.

Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally, a tooth that has had root canal therapy may require future re-treatment, surgery, or even extraction.

Recommended treatment: _____ _____ _____
Signature of Dentist Date

I have had the opportunity to read this form and ask questions. I understand the treatment, conditions, and risks involved with endodontic therapy and surgery. I also understand that upon completion of endodontic therapy in this office, I must return to my general dentist for permanent restoration of the tooth involved. My signature below indicates that I consent to the necessary or advisable treatment recommended by the endodontist.

X _____ _____
Signature of Patient or Responsible Party Date

_____
Printed Name of Patient or Responsible Party

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can be and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physicians certifications.

I have read, received, and understand your *Notice of Privacy Practices* containing a more complete description of the used and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

X_____ _____
Signature of Patient or Responsible Party — Date

_____ _____
Printed Name of Patient or Responsible Party — Relationship to Patient

Office Use Only

I attempted to obtain the patients signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:

Initials:

Reason: