Patient Information

Last Name:_____ **First Name:**_____ **M.I.:**_____

Address:_____

City:_____ **State:** _____ **Zip:** _____

Cell Phone:_____ **Alternate number:**_____

Email Address: _____

Preferred contact: Cell Text Alt # Email

Is it ok to Text confirmation appointment information? Yes No

May we leave information on voicemail/email regarding your treatment? Yes No

May we discuss your treatment with anyone else (i.e. spouse, guardian, etc.)? Yes No

If Yes, who?_____

Social Security #:_____-_____-_____ **Date of Birth:** ____/____/_____

Employer:_____

Referring Person/Dentist: _____

General Dentist: _____

Emergency contact name/phone number:_____

Acknowledgement of Privacy Practices

By my signature below, I acknowledge that I have read the Notice of Health Information Practices posted in the office, on the back of this clipboard or on our website under online forms. I understand that the organization has the right to change their notice and practices and prior to implementation, will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization had already acted in reliance thereon.

Signed _____ Today's Date _____
(Patient/Parent/Guardian)

Assignment of Insurance Benefits & Private Pay Financial Policy

Your insurance is a contract between you and the insurance company. **We are not a party to that contract and are not considered "in network" with most insurance companies.** We file dental claim(s) as a courtesy to you. We will provide any necessary forms or radiographs to you or your insurance company to aid in receiving payment. We will discuss your estimated co-payment with you; however, you must understand that what your insurance pays may differ than what was estimated, and you are ultimately responsible for the remaining balance. Also, some companies will not accept an assignment of benefits and will only reimburse the patient directly. In those instances, you may be required to pay for the treatment in full and have the insurance company reimburse you directly.

I hereby authorize and request my insurance company to pay, directly to Westlake Endodontics, P.A., the amount due on my claim for services rendered to me or my dependent by Westlake Endodontics, P.A.

I understand that I am responsible for services and charges not covered and/or not paid by my insurance. Westlake Endodontics requires payment in full be remitted no later than 30 days from the date insurance payment is received. Balances not paid within 30 days of that date will incur a $25 late fee. Balances not paid in full within 60 days of receipt of an insurance payment will be released to an outside collections agency for further action.

For non-insurance patients, payment is due, in full, at the time of service.

Cancellation of an appointment with less than 24 hours' notice will require that the estimated patient portion for that appointment be paid in full at the time the appointment is rescheduled.

Signed _____ Today's Date _____
(Patient/Parent/Guardian)

Authorization and Consent
To Send Unencrypted Patient Information by Email and Other Electronic Means

Since we are a dental specialist office, we correspond with your referring dentist and any other dental specialist that may be part of your treatment team. Email is a very convenient way to discuss complex cases with other dentists/dental specialists and to share x-rays/pictures involving the case. Unfortunately, email is not always secure; however, the methods to encrypt the data are laborious and add additional costs. We feel these methods are unnecessary and most patients do as well. But there are HIPAA laws in place that we must adhere to. We would like to continue using email as a communication tool, but we need your permission to do so.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, Westlake Endodontics may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that email, and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law.
- Westlake Endodontics does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless requested by the patient.

Until I tell you in writing to stop, I authorize Westlake Endodontics, P.A., to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or Westlake Endodontics, P.A.'s health care operations. The patient information that may be emailed may include my x-rays and treatment information. No financial data or personal information, other than your name, would be sent.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Westlake Endodontics already sent before receiving my written instructions to stop.

Patient name (please print) _____

Signature: _____ Date: _____

Patient:_____ **DOS:**_____

Dental History

What is your chief complaint?_____

Are you experiencing any discomfort <u>right now</u>? [] Yes [] No

Please rank your pain on the following scale: * * * * * * * * * * * *
Mild Moderate Severe

If no, have you experienced discomfort in the <u>past</u>? [] Yes [] No

Please rank your pain on the following scale: * * * * * * * * * * * *
Mild Moderate Severe

How long have you been experiencing this pain? _____

Please describe the pain you have/had if applicable:

[] Constant [] Intermittent [] Momentary [] Lingering [] Referred

[] Sharp Jabbing [] Dull [] Throbbing [] Aching [] Burning [] Spontaneous [] Provoked/reproducible

Is your pain affected by one or more of the following?

[] Hot [] Cold [] Biting [] Palpation [] Manipulation [] Head position

Have you noticed any swelling or a "gum boil"? [] Yes [] No **If yes, is it enlarging?** [] Yes [] No

Which medications have you taken or been given for the pain? (pain meds, antibiotics, etc.)

Doctor's Notes:_____

_____

_____

_____

_____

Patient:_____ **DOS:**_____

Medical History

******Please inform us if you have any COVID19 symptoms such as fever, cough, SOB, loss of smell/taste, etc., have tested positive for COVID19 or have been in contact with someone who has tested positive. If so, please do not come to your appointment and reschedule until you are symptom free for 14 days.**

Please check if you have had or currently have any of the conditions listed below:

CARDIAC
- o High Blood Pressure
- o Chest Pain/Angina
- o History of Heart Attack / When:_____
- o Arrythmia/A-Fib/Pacemaker
- o Heart Defect
- o Prosthetic/replacement heart valve
- o History of endocarditis/heart infection
- o History of heart surgery

RESPIRATORY
- o Shortness of breath
- o Bronchitis or Emphysema
- o Asthma, wheezing
- o Tuberculosis/cough, blood in sputum
- o Nosebleeds/sinusitis

GASTROINTESTINAL
- o PUD,GERD
- o Hepatitis A, B, C
- o Jaundice, liver disease

GENITOURINARY
- o Kidney problems
- o Sexually transmitted disease

ENDOCRINE
- o Thyroid problems
- o Diabetes

PSYCHIATRIC
- o Anxiety/depression
- o Dental anxiety / Scale 1-10_____

HEMATOPOIETIC
- o Easy bruising, bleeding
- o HIV, AIDS, other infectious disease
- o Leukemia/lymphoma
- o Problems with immune system
- o History of stroke/TIA

NEUROLOGICAL
- o Headaches, Dizziness, Fainting
- o Seizures/Epilepsy
- o Paresthesia, neuralgia

GROWTH OR TUMOR
- o History of cancer
- o Radiation or Chemotherapy
- o Surgery for cancerous growth/tumor

OTHER
- o Tobacco
- o Recreational drug use
- o Prosthetic joint replacement (hip, knee, etc.)
- o Glaucoma
- o Are you pregnant?_____ Due date:_____
- o Osteoporosis/osteopenia
- o IV medication for osteoporosis or osteopenia?
- o Latex allergy
- o Epinephrine sensitivity

Do you have to take antibiotics before dental visits due to a heart condition or joint replacement? Y or N

Allergies: _____

Do you have any disease or condition not listed?_____

Please list any prescription medications: _____

_____

I certify that any and all questions I have about the inquiries above have been answered to my satisfaction. I have answered the questions truthfully and completely. I will not hold Westlake Endodontics, P.A. responsible for any complications that result from any errors or omissions that I may have made.

PATIENT/guardian signature:_____**Date**:_____

Vital signs: BP:_____**Pulse:**_____**Weight:**_____**ASA Status:**_____ **SpO2:**____ **% Temp:**_____

Consent Form For Non-surgical Root Canal Therapy

A root canal is the process of removing diseased or infected tissue from inside the tooth root and replacing the space with a filling material. Re-doing a root canal, also known as a re-treatment, involves removing the previous root canal filling material, cleaning the root canal system and filling it with new material. Unfortunately, there is no guarantee that root canal therapy, or any dental/medical procedure, will be successful. Although root canal therapy is highly predictable, some may need to be re-done or followed with additional treatment. We will gladly inform you of all your alternative treatment options. As patients ourselves, we always want to know the risks and benefits of any procedure and we extend the same courtesy to our patients. Here are a few things we would like you to know about root canal therapy:

1. Provided root canal therapy is performed, you may leave our office with a temporary filling. If so, please make sure you see your dentist for the permanent restoration ASAP or within the discussed timeframe. Failure to do so may decrease the success of root canal therapy. We will advise you and attempt to call your dentist's office if this is necessary.
2. It is common and normal to have some discomfort after root canal therapy depending on your diagnosis. This may last from days to weeks after the procedure. Please refer to the post-op instructions.
3. If you were told that you have a dark spot/lesion/abscess in your jaw bone at or alongside the end of the root, follow up is necessary within 6 months to make sure that area is healing after treatment. You may feel normal, but the dark spot could be growing and eventually cause additional complications. We will contact you via phone for this no-charge follow up visit.
4. In an attempt to navigate curved, calcified (tight) or narrow root canals, instruments used during the procedure may separate inside the root canal. In some cases, the separated instrument may not be removed and will be incorporated in the filling material.
5. In an attempt to find blocked or "calcified" nerves, an opening to the outside of the tooth may occur. This is called a perforation. Usually this can be repaired.
6. When redoing or retreating old root canals, calcifications and blockages (i.e. ledges or separated instruments) may exist which occasionally are impossible to detect ahead of time. This may result in the need for additional treatment such as root canal surgery or extraction of the tooth.
7. Cracks that extend down the root surface cannot be easily detected. A microscope is used that helps us locate as many as possible. Cracked teeth may need additional treatment in the future including extraction of the tooth.
8. If the tooth we are working on has an existing restoration (crown, bridge, veneer, etc.) sometimes these restorations must be drilled through and cannot be removed prior to treatment. Occasionally these restorations may crack, chip or even break requiring repair or replacement. We may be able to repair it but if they require replacement, this would be done by your restorative dentist at an additional cost.
9. If you have a history of TMJ pain or discomfort, having your mouth open during treatment may temporarily increase your symptoms. Please let us know if you have a history of TMJ issues so we can make treatment adjustments.
10. During root canal therapy or any dental procedure, it is usually necessary to administer local anesthesia to the area being treated. While this is a very safe procedure, there are a few rare complications that can occur which may lead to discomfort, bleeding or in very rare cases, prolonged paresthesia (numbing), dysesthesia or altered sensation in the area.
11. If we are doing internal bleaching on a tooth, while very minimal, there is a slight risk of external resorption
12. Additional concerns:_____

Please let us know if there is something you don't understand so we may explain it more in depth. We encourage and welcome any questions you may have about your treatment options.

Planned procedure:_____

All my questions have been answered to my satisfaction and the alternative treatment options have been explained to me including no treatment.

Signature_____**Date**_____

(patient/parent/guardian)