Endodontic Associates
Practice Limited to Endodontics

PATIENT INFORMATION
Please Fill Out

Mr. ☐
Mrs. ☐
Miss ☐ _____

Social Security Number: ___ - ___ - ____

Home Address: _____

Date of Birth: ___ / ___ / ____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) -

Employer (if minor, Parent's Employer): _____

Business Phone: ( ) -

Business Address: _____

Cell Phone: ( ) -

Email Address: _____

Name of Spouse (or parent's if minor): _____

Spouse's (parent's) SSN: ___ - ___ - ____

Spouse's (parent's) Employer: _____

Spouse's (parent's) Birth Date: ___ - ___ - ____

Person to Contact in Case of Emergency: _____ Relationship to Patient: _____

Phone: ( ) -

Physician: _____

Phone: ( ) -

Referring Dentist: _____

Dental Insurance: YES: ☐ NO: ☐

Name of Insured/Subscriber: _____ Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child Subscriber's DOB: ___ / ___ / ____

Policy / ID Number: _____

Name of Insurance Company: _____ Telephone Number: ( ) -

Group Number: _____

INFORMED CONSENT

This is my consent to the endodontic procedures indicated and any other procedures deemed necessary or advisable as a corollary to the planned endodontic therapy performed by Endodontic Associates and any assistant the may require. I agree to the use of local anesthesia sedation, and/or analgesia, depending upon the judgement of the endodontist. Complications of root canal therapy and anesthesia may include swelling, discomfort, infection, bleeding, sinus involvement, and numbness or tingling of the lip, gum or tongue, which rarely is protracted and even more rarely is permanent.

I understand root canal therapy is a procedure to retain a tooth which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery, or even extraction.

I also understand that only the root canal therapy is to be performed at this office. The permanent (outside) restoration (filling, onlay, crown, etc.) will be done by my regular dentist.

I understand that medications for pain and sedation may cause drowsiness which can be increased by the use of alcohol or other drugs. I will avoid operating any vehicle or hazardous devices while taking such medications. I further understand that certain medications may cause hives and intestinal problems and, if any of these reactions occur, I am to call the doctor immediately. I understand that it is my responsibility to report any changes in my medical history.

All reasonable collection and/or legal costs required to collect fees due Endodontic Associates will be borne by the undersigned.
ALL SIGNATURES MUST BE BY PARENT OR GUARDIAN IF PATIENT IS 18 YEARS OR YOUNGER.

_____

Date Signature

PLEASE COMPLETE BOTH SIDES

Name: _____

MEDICAL HEALTH QUESTIONNAIRE

Are you currently under the care of a physician? YES: ☐ NO: ☐

If yes, please describe: _____

History of Hospitalization: _____

_____

Any Allergies: _____

_____

Medications Presently Taking: *(including aspirin, etc.)* _____

_____

ANY FAMILY HISTORY OF *(circle)* **Heart Disease Cancer Diabetes Seizures**

HAVE YOU EVER HAD OR HAVE YOU NOW: *(please check all that apply)*

(Check each item)	YES	NO	DON'T KNOW
Epilepsy or Seizures	☐	☐	☐
Fainting or Dizziness	☐	☐	☐
Nervousness	☐	☐	☐
Stroke	☐	☐	☐
Glaucoma	☐	☐	☐
Cold Sores (Herpes)	☐	☐	☐
Persistent Cough	☐	☐	☐
Emphysema	☐	☐	☐
Tuberculosis/PPD Positive	☐	☐	☐
Asthma	☐	☐	☐
Hay Fever	☐	☐	☐
Sinus Problems	☐	☐	☐
Anemia	☐	☐	☐
Sickle Cell Disease	☐	☐	☐

(Check each item)	YES	NO	DON'T KNOW
Hemophilia	☐	☐	☐
Bruise or Bleed Easily	☐	☐	☐
Heart Problems or Angina	☐	☐	☐
Hypertension	☐	☐	☐
Rheumatic Fever	☐	☐	☐
Heart Murmur	☐	☐	☐
Mitral Valve Prolapse	☐	☐	☐
Congenital Heart Lesions	☐	☐	☐
Heart Surgery	☐	☐	☐
Prosthetic Heart Valve(s)	☐	☐	☐
Pacemaker	☐	☐	☐
Blood Transfusion(s)	☐	☐	☐
Liver Disease	☐	☐	☐
Yellow Jaundice	☐	☐	☐
Hepatitis - type:	☐	☐	☐

(Check each item)	YES	NO	DON'T KNOW
Ulcers	☐	☐	☐
Kidney Problems	☐	☐	☐
Venereal Disease	☐	☐	☐
Diabetes	☐	☐	☐
Thyroid Disease	☐	☐	☐
AIDS / HIV - III Positive	☐	☐	☐
Arthritis	☐	☐	☐
Painful Joint(s) (incl. jaw)	☐	☐	☐
Prosthetic Joint(s)	☐	☐	☐
Hives	☐	☐	☐
Steroid Medications	☐	☐	☐
Drug Addiction	☐	☐	☐
Alcoholism	☐	☐	☐
Unexplained Weight Changes	☐	☐	☐
Cancer / Radiation Therapy	☐	☐	☐

1. HAVE YOU EVER BEEN TOLD THAT YOU SHOULD NOT DONATE BLOOD?	☐	☐	☐
2. FEMALES: Are you taking birth control pills (BCP's)	☐	☐	☐
Are you or might you be pregnant?	☐	☐	☐
3. DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE?	☐	☐	☐

If yes, please describe: _____

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FINANCIAL POLICY

As specialists in the practice of endodontics (root canal therapy), we are committed to providing you with the highest level of care. Unlike other dental services, our treatment is usually completed in one or two visits. Therefore, payment for services rendered is expected when your treatment is completed. If we are able to complete root canal therapy in one visit, the fee for that service is due at that time. If you are required to return to our office for a second visit in order to complete your root canal, payment for the entire treatment may be divided equally between the visits.

If you provide our office with complete dental insurance information, we will gladly inquire on your behalf to verify what benefits may be applied to your fee for our services. If your insurance benefits entitle you to a reduced fee or provide for payment to our office (except for deductible or co-payment), your portion of the balance is expected at the time of service. Our office will then submit your claim to your insurance company on your behalf for reimbursement., All co-payments are estimates until payment is received from the insurance company, any portion not covered will be the patient's responsibility. **We are not responsible for any misquotes by either our office or your insurance company. Please keep in mind that dental insurance is a contract between you and your insurance company.** Therefore, if we do not receive payment from your insurance company within 30 days, the unpaid balance of your account becomes your responsibility. We will assess a monthly late fee of 1.5% on any outstanding accounts.

All reasonable collection and/or legal fees required to collect fees due Endodontic Associates will be borne by the undersigned.

We understand that occasional errors may occur in the processing of insurance claims. If you believe that an error regarding your account has occurred, please do not hesitate to contact our office. We will make every effort to rectify the problem in the timeliest manner possible. Your referral to our office indicates the confidence that your general dentist has in us for providing you with the best of care possible for this type of dental service. It is important to realize that your general dentist may participate with insurance companies other than those with whom we participate.

Your signature below indicates that you have read this statement and that you understand your responsibilities regarding payment prior to the initiation of any treatment by the doctors in our practice.

Print Name **Signature (SEAL)** **Date**

PLEASE COMPLETE BOTH SIDES

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❑ **Clinton Business Center**
7905 Malcolm Road, #300
Clinton, Maryland 20735
301-868-5500

❑ **Lakeview Professional Park**
605 Post Office Road, #202
Waldorf, Maryland 20602
301-843-3290

❑ **College Park**
6201 Greenbelt Road, #U-11
College Park, Maryland 20740
301-345-3800

❑ **California**
22888 Three Notch Road
California, Maryland 20619
301-737-5507

PATIENT CONSENT FORM

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 and will be used to:

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

I have been informed by you of your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such ***Notice of Privacy Practices*** prior to signing this consent. 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 at the address below 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.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Please use the space provided to list the people to whom you give written authorization for us to disclose your health and financial information to:

Spouse/Significant other: _____

Family Member: _____ **Relationship:** _____

Other: _____ **Relationship:** _____

Signed this _____ **Day of** _____**, 20**_____

Print Patient Name: _____

Relationship to Patient _____

Signature _____