PATIENT REGISTRATION

Name_____ Birthdate_____ Home Phone_____

Social Security #_____ Cell Phone_____

Address_____ City_____ Zip_____

Check One ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient or Parent's Employer _____ Work Phone_____

Spouse or Parent's Name _____

RESPONSIBLE PARTY

Name _____ Relationship to Patient _____

Address _____ Home Phone _____

Drivers License# _____ Birthdate _____

Employer_____ Work Phone_____

Office Payment Policy

The best doctor-patient relationships are maintained when there is complete understanding of the treatment rendered and the fee. Please feel free to discuss the fee prior to treatment. As a courtesy we will submit insurance, but we can not accept the responsibility for collecting insurance payments or for negotiating a disputed claim. Insurance is a contract between the patient and the insurance carrier. Even though you are covered by dental insurance, there will be a copay due on the day of your visit. Since it is not possible to predict the exact amount of the insurance payment, you can expect either an overpayment refund or a bill for the uncovered portion of the fee after the insurance payment is received by our office.

For your convenience we offer the following methods of payment: Please check one

☐ Cash ☐ Visa - MasterCard - Discover ☐ Personal Check

DENTAL INSURANCE (If you have a secondary dental insurance, please inform the front desk.)

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birth Date _____ Social Security # _____

Name of Employer _____ Work Phone _____

Insurance Company _____ Group # _____

Insurance Company Address _____ Telephone # _____

I authorize release of any information relating to this claim. I understand that my dental insurance may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents. I authorize and request my dental insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

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Signature of Patient or Parent

Our office does not transmit claims electronically, so we are not required to distribute and obtain an Acknowledgement Notice of our privacy practices in writing. However, we do take our patient's health information seriously, and we will make every effort to protect privacy. It is our policy that we only disclose patient health information about treatment, payment, and healthcare operations. Any other disclosure of health information would require a written authorization.

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Signature of Patient or Parent

CONSENT TO EXAMINE AND TREAT

You have been referred for endodontic (root canal) evaluation and, if necessary, treatment. The consultation consists of history taking, clinical examination, appropriate tests, and diagnostic radiographs (X-rays). A diagnosis and treatment recommendation will be presented.

Root canal therapy is completed in one or more separate appointments. The objectives of this treatment are: to relieve pain and infection, if present; remove the diseased pulp tissue; and clean, disinfect and fill the root canals. Radiographs will be required during the treatment. Local anesthetics are usually required. And antibiotics and analgesics may also be needed.

The following possible risks may occur at any time during treatment.

RISKS: Complications resulting from, but not limited to, the use of dental instruments, drugs, sedation, medicines, anesthetics, and injections. These complications include: swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gum, cheeks and teeth, which is transient but on occasions may be permanent reactions to injections, changes in occlusion (biting), jaw muscle cramps and spasms, tempromandibular (jaw) joint difficulty, referred pain to ear, neck and head, nausea, vomiting, allergic reactions, delayed healing, sinus perforations, and treatment failure.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY: The risks include the possibility of instruments broken within the canals, perforations (extra openings) of the crown or root of the tooth, damage to bridges, existing fillings, crowns or porcelain veneers, loss of tooth structure in gaining access to the canals and cracked teeth. During treatment complications (such as; blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal [gum] disease, splits or fractures of teeth) may be discovered which make treatment impossible or which may require dental surgery.

TREATMENT CHOICES OTHER THAN ENDODONTIC THERAPY: These include no treatment, waiting for more definite symptoms, and tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infection to other areas.

ACKNOWLEDGMENT AND CONSENT: I, the undersigned, being the patient or guardian of a minor patient, acknowledge that I have read this form and consent to the performance of the described procedures. I reserve the right to refuse further treatment at any time and accept the consequences of that decision. I also understand that I may need to return to my general dentist for permanent restoration of the tooth.

I understand that root canal treatment is an attempt to save the tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed and additional treatment such a surgery or extraction may be necessary.

Date: _____ Signature: _____ Witness: _____
If minor, parent or guardian