**Patient Health Information**

Legal Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nickname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First MI

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street Apt. #

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City State Zip Code

Preferred Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Circle one: Cell / Home / Work Cell / Home / Work Cell / Home / Work

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ \_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_

 Date of Birth (MM/DD/YEAR) Social Security Number

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name Phone #

**Have you ever had any of the following? Please check those that apply.**

* Epilepsy
* High Blood Pressure
* HIV
* Hepatitis
* Cancer
* Liver Disease
* Mental Disorders
* Nervous Disorders
* Heart Valve Replacement
* Currently Pregnant
* Diabetes
* Medication Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Artificial Joints
* Blood Disease
* Stroke
* Tuberculosis
* Respiratory Problems
* Rheumatism
* Heart Disease

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently being treated for any medical conditions not listed above?

If yes please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you EVER taken one of the following medications?**

* **Actonel**
* **Fosamax**
* **Boniva**
* **Didronel**
* **Reclast**
* **Prolia**
* **Aredia**
* **Plavix**
* **Eliquis**
* **Warfarin**
* **Coumadin**

General Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PCP Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you require a Premed (Antibiotics) before undergoing

any dental procedures? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ General Dentists Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ I **DO NOT** have Dental Insurance

**Secondary Dental Insurance Information**

Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscribers Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscribers DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Dental Insurance Information**

Insurance Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscribers Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscribers DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I have any change in my health or personal information, I will inform Smart Endodontics at my next appointment.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SMART ENDODONTICS FINANCIAL AGREEMENT

**Patients with In Network Dental Insurance**

Our office is currently in network with two dental insurance companies, Northeast Delta Dental (**We are a PREMIER PROVIDER**) and the Cigna Total Plan. If you would like a cost estimate of your co-pay, please request one prior to your appointment. If treatment is completed in one visit, your copayment must be received in full at that time. If more than one visit is required, payment may be split into two equal payments. If needed we also offer an in-house financing option. **Please keep in mind; this is only an estimate and coverage verification does not guarantee payment. It also does not guarantee the estimated cost given to you is the total amount due.**

**Patients with Out of Network Dental Insurance**

We accept and submit to all out of network insurance companies with **the exception of Medicare/Medicaid**. **If treatment is completed in one visit, your out-of-pocket cost must be received in full at that time**. If more than one visit is required, payment may be split into two equal payments**.** We do accept CARE CREDIT and offer an in-house financing option. Patients who pay with cash can receive a 10% discount. This does not include a check or debit card.

**Patients without Dental Insurance**

Patients who do not have any dental insurance are required to pay in full by the completion of treatment. **If treatment is completed in a single visit, full payment is due at that time**. If more than one visit is required, payment may be split into two equal payments. We do accept CARE CREDIT and offer an in-house financing option. Patients who pay with cash can receive a 10% discount. This does not include a check or debit card.

**Refunds/Remaining Balance**

We will file your insurance claim electronically the day of your appointment to expedite payment. If the insurance payment is less than the estimated amount, you will be responsible for the balance. Failure to pay the remaining balance within 90 days will result in our accounting office posting your debt to a collections agency**. If it becomes necessary to post your debt to a collection’s agency, the amount of the total remainder owed will be increased by 30%.** If the insurance payment is more than the estimated amount owed, you will be sent a refund check from our accounting office at the completion of your treatment.

I authorize the office of Smart Endodontics to release any and all information concerning the patient’s treatment to all insurance companies for claims submitted and to verify insurance coverage for myself and/or spouse/dependents. I also authorize any insurance benefits to be paid directly to Smart Endodontics. I understand that **any amount unpaid by insurance is my responsibility**. If it becomes necessary for my account to be placed with a collection agency, I understand that I will be responsible for the collection fee of 30% and that it will be added to the past due balance. I acknowledge that I have read and understand the financial policy for Smart Endodontics, PC. All insurance claims are sent upon the completion of any procedure and will take approximately 30 days to process**. I understand that I am ultimately responsible for this account** and should watch for the explanation of benefits from my insurance company to ensure that the claim is processed expeditiously.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Pharmacy Information**

SMART ENDODONTICS

INFORMED CONSENT FOR ENDODONTIC (ROOT CANAL) TREATMENT

Root canal therapy consists of procedures aimed toward the preservation and retention of teeth, which might otherwise require extraction. There is a high degree of clinical success with root canal treatment, but since it is a biological procedure, **results cannot be guaranteed**. Occasionally, a tooth which has received root canal treatment will require retreatment, surgery, or extraction.

**Potential risks and complications exist with any treatment. These include, but are not limited to:**

* Post-operative discomfort or sensitivity, which may require pain medication
* Post-operative swelling or infection, which may require additional treatment or antibiotics
* Restrictive mouth opening (trismus), a change in the bite, or injury to the jaw/joints
* Incomplete healing, which may require retreatment and/or root canal surgery or extraction
* Instrument separation in the canal
* Perforations (extra openings) of the canal with instruments
* Blocked root canals that cannot be ideally completed
* Tooth and/or root fractures that may require extraction
* Fracture, chipping, or loosening of an existing tooth or crown/bridge
* Temporary or permanent numbness
* Reactions to anesthetics, materials, or medications used in the procedure

Alternatives to root canal treatment include no treatment, waiting for more definite symptoms to develop, and tooth extraction. The risks involved with these choices include, but are not limited to: pain, infection, swelling, and loss of the tooth.

**Proper post-treatment restoration for the treated tooth is necessary. Please contact your dentist within one month of completion of treatment for final restoration of the tooth (filling, crown, or bridge). Most root canal therapy teeth will require a crown. Avoid chewing hard foods with the tooth until the final restoration has been completed. Otherwise, the tooth may break or split and require extraction.**

Some patients that have completed root canal therapy may need a follow-up appointment to check that the tooth and surrounding areas are healing properly. These patients will receive a postcard in the mail from Smart Endodontics when it is time to schedule this appointment.

Please sign below to acknowledge you’ve read the above and consent to treatment.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Dental Insurance Information**

Insurance Company Name: ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscribers Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscribers DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Smart Endodontics**

**Medical Information Release Form**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release of Information**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize the release of my confidential health information, in its entirety, to the persons/facility/entity listed below:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ] **DO NOT** release my health information to anyone.

This release of informationwill remain in effect until terminated by me in writing.

**Messages**

If unable to reach me at the numbers provided on my registration form:

[ ] You may leave a **detailed** message on my voicemail

[ ] Please leave a message requesting a call back

[ ] Do not leave a message

You may request a copy of our privacy practices at the front desk.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_