Your health and comfort are dependent upon an accurate knowledge of your medical history. Many medical conditions can interact with procedures or drugs used in dentistry. Therefore, please fill out the following carefully. This information will be kept confidential. *Thank you.*

# Patient Medical History

NAME_____ BIRTHDATE_____

ARE YOU CURRENTLY UNDER ANY TYPE OF MEDICAL CARE (If yes, explain)_____

_____

PLEASE LIST ALL THE MEDICATIONS YOU ARE TAKING (Include non-prescription)_____

_____

ARE YOU ALLERGIC TO OR HAVE HAD A REACTION TO:
Local Anesthetics (Novocain) _____ Antibiotics (Penicillin, others) _____Aspirin or Ibuprofen (Motrin) _____
Narcotics (Codeine)_____ Others (Latex, Bleach, Nickel, Cloves?)_____

**HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? (Please check each)**

| Yes/No | Yes/No | Yes/No |
|---|---|---|
| __ __ High Blood Pressure | __ __ Panic Attacks | __ __ Asthma |
| __ __ Heart Attack/Angina | __ __ Fainting/Seizures | __ __ Ulcers/Gastric Reflux |
| __ __ Heart Murmur / MVP | __ __ HIV (+) or AIDS | __ __ Sinus problem |
| __ __ Hospitalized Surgery | __ __ Diabetes | __ __ Bisphosphonate use (fosamax, actonel) |
| __ __ Stroke | __ __ Thyroid Disease | __ __ Cancer/Tumors |
| __ __ Kidney Disease | __ __ Tuberculosis/PPD(+) | __ __ Glaucoma |
| __ __ Artificial Joint or Implant | __ __ Hepatitis (Type A,B,or C) | __ __ Other (Please Explain) |

Other conditions _____

_____

Your Physician(s) _____

Dentist _____

Women Only: Are you pregnant? ____ Delivery Date_____ Are you taking birth control pills? ____
*(Antibiotics are often prescribed in the course of Root Canal Therapy. They can interfere with the absorption of birth control pills, thus making them ineffective. While taking antibiotics, alternative methods of contraception are recommended.)*

Today's Vital Signs BP /

**PERMISSION FOR ROOT CANAL PROCEDURE**

Once indicated, the only option for Root Canal Therapy is tooth extraction. Avoiding treatments puts you at a greater risk for further pain and the spread of infection. Root canal therapy has a high level of predictable success (up to 97%), yet like any treatment which deals a biological system, no guarantees are made. Certain treatment factors such as; anatomy of the tooth, breakage of endodontic instruments, restoration fractures, tooth and root fractures, previous root canal treatments, perforations, ledges and obstructions, overextended materials, and/or the patient's immune response are beyond the doctor's control. Despite Dr. Moyer's meticulous approach to root canal therapy, treatment can still fail. Occasionally additional surgical procedures are required as a consequence of treatment. I understand that the benefits of root canal therapy (retaining my tooth, elimination of pain and/or infection) outweigh the minimal risks (less than 5%) of having treatment (including possible pain, swelling, long term altered tooth sensations, need for additional procedures including new restorations, surgery, retreatment tooth extraction). I consent to the performing of whatever procedure may be decided upon to be necessary or advisable in the opinion of the doctor. I also understand that only the root canal treatment is to be done at this office. The permanent (outside) restoration (filling, crown, etc.) is to be completed by my regular dentist. Failure to have my tooth promptly restored can result in fracture, contamination of the root canal (requiring retreatment) and/or eventual tooth loss. Local anesthetics used in this and all other dental procedures have risks of possible systemic reactions, altered nerve sensations (temporary and permanent), infection, and tissue damage.

*I have read, understand and agree to the above informed consent. I have had an opportunity to ask any questions.*

*Signed*_____*(Today's Date)*

# Patient Registration

**Name** _____
(Last Name) (First Name) (Initial)

**Address** _____**City** _____**State** _____**ZIP** _____

**Sex:** M F **Date of Birth:**___/___/___ **Status:** Single Married Widowed Divorced

**Home/Cell Phone #**_____**Work Phone #**_____**SSN #**_____

**Employer** _____**Occupation**_____

**Address** _____**City**_____ **State** _____ **ZIP** _____

**Spouse Name** _____ **SSN #**_____

**Employer** _____ **Occupation** _____

**Address** _____**City** _____**State**_____ **ZIP** _____

**Spouse Date of Birth:** ___/___/___

**In Case of Emergency Contact** _____**Day Phone #**_____

# Dental Insurance Information

*Must be Fully Completed for our Office to Accept Your Dental Insurance*

*Primary Dental Insurance*

**Employee** _____**Member ID# /SSN #** _____

**Employer** _____**Day Phone #**_____

**Address** _____**City** _____**State** _____**ZIP**_____

**Insurance Co. Name** _____**Group Number** _____

**Address** _____**City** _____**State** _____**ZIP**_____

**Insurance Co. Phone #** _____ **Relationship to Employee** Self Spouse Child Other

***Insured's Signature*** _____ **Date** _____

**INSURED PATIENTS:** In order for us to accept your dental insurance the above insurance information must be complete and verifiable. For patients who do not provide complete insurance information, payment is due in full at the time of service. Please note dental insurance rarely covers 100% of your treatment costs. Most plans claim to cover root canal therapy at 80%; however, due to UCR (usual, customary, and reasonable charges) levels the actual dollar amounts are closer to 66%. Because of this we request that 1/3 of your treatment fee be paid at time of treatment, unless otherwise specified. **Any remaining balance** (after insurance payment) **is due in full upon notification by statement.** You are ultimately responsible for the entire fee, regardless of your insurance coverage. Denial of benefits, surpassed annual maximum benefit, fees above UCR levels, or Managed Care stipulations will not cause dismissal of incurred fees. Outstanding insurance balances of 90 days will be reassigned to the patient, with payment required within 10 days. Balances may be financed through credit cards. For **Delta Dental or Delta Dental Premier Plan** subscribers, a co-pay or a portion of your treatment not covered by your plan may be due at the time of service.

**Patient initials**

**NON-INSURED PATIENTS:** For those patients without dental insurance, payment is due in full at the time of service. Payment made in the form of cash, personal check, *MasterCard*, *Discover* or *VISA* is usually accepted.

**Patient initials**

**FEES:** Treatment fees discussed with patients prior to consultation represent an estimate only. A consultation fee may be charged in addition to treatment fees. The patient agrees to be financially responsible for broken appointment fees, fees associated with NSF penalties and legal fees necessary for collection of delinquent accounts. Outstanding balances over 30 days will be subjected to a finance charge of 18%APR.

If root canal treatment is started and not completed, a portion of the quoted fee will be assessed at Dr. Moyer's discretion.

**Patient initials**

***Today's Payment will be by:*** **Cash /Check** **Visa/MasterCard/Discover/AMX**

*The patient assumes full financial responsibility for any fees incurred, despite any insurance coverage. In the case of a minor patient, the legal guardian assumes full financial responsibility. I have read, understand and agree to the provisions of the financial policies. I authorize release of all my treatment and personal information for the purpose of filing insurance claims and/or treatment by other designated health care providers.*

**Patient's Signature** _____ **Date** _____

# PATIENT PRIVACY POLICY

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPPA) to *simplify* administration, assure portability of health insurance coverage and facilitate communication of medical records and other information between healthcare providers and health plans. This act requires an explanation of our privacy policies.

Your privacy is now and has always been respected. At no time will your information be sold, given for surveys or be available for public viewing. We maintain physical, electronic, and procedural safeguards that comply with our professional standards. Information we obtain regarding your personal status (name, address, social security number, etc.) your insurance carrier, health history and endodontic treatment are routinely given out of our office in the following manner:

- A report of your treatment along with duplicate x-rays is sent to your referring dentist (or dentist of your choosing) to facilitate your tooth's care.
- An insurance claim containing required filing information (name, address, employer, group number, etc.) is filed with insurance carrier (information provided by you).

Information given out of our office on occasion includes:

- Duplicate radiographs with treatment information are presented to professional journals, study clubs or other healthcare providers for the express purpose of professional education. *At no time are names, or other potentially identifiable characteristics included in these materials.*
- Information necessary for the collection of delinquent accounts
- Information of care given to employers (work excuse) per your request only

If you have any further questions regarding these policies or your rights please ask.

I have read and agree to the provisions of the **Patient Privacy Policy** statement.

Patient's Signature_____ Date_____

I authorize permission to release my dental information to:

Name _____ Phone_____

Name _____Phone_____