Advanced Endodontics

(PLEASE PRINT)

PATIENT'S NAME _____ DATE OF BIRTH _____

HOME ADDRESS _____ CITY _____ STATE _____

EMAIL ADDRESS _____

DRIVER'S LICENSE NO. _____ ZIP _____

SOCIAL SECURTY NO. _____ HOME PHONE _____

EMPLOYED BY _____ BUS. PHONE _____

BUSINESS ADDRESS _____ CELL/PAGER NUMBER _____

SPOUSE OR PARENTS NAME _____

SPOUSE OR PARENTS EMPLOYED BY _____ BUS. PHONE _____

REFERRED BY DR. _____

PERSON RESPONSIBLE FOR ACCOUNT (Guarantor) _____

IF INSURED, DENTAL INS. CO., CONTRACT # & ADDRESS _____

_____

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD (Please check if **YES**)

- ☐ HEART DISEASE OR HEART ATTACK
- ☐ HEART MURMUR
- ☐ PROLAPSED MITRAL VALVE
- ☐ RHEUMATIC FEVER
- ☐ RHEUMATIC HEART DISEASE
- ☐ STROKE
- ☐ HEART SURGERY
- ☐ PACE MAKER _____
- ☐ PROSTHETIC (ARTIFICIAL) HEART VALVE
- ☐ HIGH BLOOD PRESSURE
- ☐ ANGINA
- ☐ CONGENITAL HEART DEFECT
- ☐ OTHER HEART CONDITIONS _____
- ☐ TUBERCULOSIS
- ☐ EMPHYSEMA
- ☐ ASTHMA/HAY FEVER
- ☐ SINUS TROUBLE/ALLERGIES
- ☐ HEPATITIS (JAUNDICE)
- ☐ JOINT REPLACEMENT (HIP, KNEE, ETC.)
- ☐ STOMACH ULCERS
- ☐ DIABETES
- ☐ THYROID DISORDERS
- ☐ STEROID THERAPY
- ☐ EPILEPSY
- ☐ FAINTING SPELLS OR SEIZURES
- ☐ BLOOD TRANSFUSION
- ☐ BLEEDING PROBLEMS
- ☐ ANTICOAGULANTS (BLOOD THINNERS)
- ☐ ANEMIA (LOW BLOOD)
- ☐ LEUKEMIA
- ☐ SURGERY IN THE PAST YEAR
- ☐ LIVER DISEASE
- ☐ TMJ (JAW JOINT) PROBLEMS
- ☐ CANCER, TUMOR
- ☐ VENEREAL DISEASE
- ☐ DRUG DEPENDENCY
- ☐ HIV POSITIVE
- ☐ ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)
- ☐ DO YOU TAKE MEDS FOR OSTEOPORSIS (i.e. Fosamax, Actonel, Reclast, etc.)
- ☐ OTHER MEDICAL CONCERNS _____

DO YOU WANT NITROUS OXIDE (LAUGHING GAS)? YES _____ NO _____

ARE YOU TAKING ANY MEDICATIONS? YES _____ NO _____

PLEASE LIST MEDICATION YOU ARE TAKING

_____

ARE YOU ALLERGIC TO:

- ☐ ASPIRIN
- ☐ PENICILLIN
- ☐ CODEINE
- ☐ NOVOCAINE
- ☐ IBUPROFEN
- ☐ OTHERS (Please List) _____

ARE YOU PREGNANT? YES ____ NO ____

ARE YOU UNDER THE CARE OF A PHYSICIAN? YES _____ NO _____

IF SO, WHY? _____

PHYSICIAN'S NAME & PHONE # _____

Signed: (Guarantor) _____ Date: _____

Advanced Endodontics, P.C.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.99 for each page, $11.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Katrina Henrickson

Telephone: (205) 933-8544 Fax: (205) 933-8412

E-mail: adv_endo@bellsouth.net

Address: 1500 20th Street South; Birmingham, Alabama 35205

Advanced Endodontics, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Office Payment Policy

The best patient-doctor relationships are maintained when there is a complete understanding of the treatment rendered and the fee. To avoid misunderstandings concerning payment please read the following:

This is a referral practice, and a mutual respect to obligations is essential to permit our business to be conducted on an efficient and friendly basis. Therefore, to avoid misunderstandings concerning payments of accounts, please note that endodontic treatment is usually completed in one visit, and must be paid in full the day of service. We will be happy to file insurance claims for you at no extra charge. In addition, you must provide our office staff with the proper information (Dental Insurance Card, Social Security #, and Date of Birth of the person under which you are filing dental insurance). **For patients that we are filing dental insurance for, 60% of the total charges is due and payable to our office the day treatment is rendered.**

Your insurance is a contract between you as a subscriber, and the insurance company as insurer, involving our office, Advanced Endodontics, P.C. only indirectly. Therefore, any controversy, which might arise over your insurance company's handling of your claim, is for you to resolve. We will be happy to assist you in any way that we can. Any discrepancy between the insurance company's allowance and your total indebtedness remains your responsibility. All payment decisions are made by your insurance company upon receipt of the claim. **This is not a PPO, PMD or HMO office.** Any insurance claim that has not been paid in 45 days of treatment will be billed back to you.

If your dental coverage is through **Blue Cross Blue Shield** we will file your insurance for you. **Blue Cross may not cover your treatment since we are not a PPO provider. Therefore, we expect payment in full the day of service.** Many of our Blue Cross patients choose to use the third party financing option with care credit.

( ) I have dental insurance ( ) I do not have dental insurance

PAYMENT OPTIONS

( ) I will pay in full with cash or check (5% discount)
( ) I will charge to MasterCard_____Visa_____Discover____American Express_____
( ) I will use third party financing – 6 month interest free. Extended terms (with interest) are available.

I hereby assign, transfer, and set over to Advanced Endodontics, P.C. all rights, title and interest to my dental reimbursement benefits under my insurance policy, I authorize the release of any dental information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand I am financially responsible for all charges for my dependents, or myself whether or not they are covered by insurance. In the unlikely event this account is submitted for collection, I the undersigned agree to pay any, and all collection costs, and reasonable attorney's fees.

Guarantor Signature: _____

Advanced Endodontics, P.C.
Endodontic (Root Canal) Informed Consent

1. The purpose of root canal therapy is to retain teeth in which the pulp has become inflamed or infected that otherwise would have to be extracted.
2. Treatment will require a series of diagnostic radiographs and may require multiple visits. It is important that you maintain scheduled appointments or the infection can reoccur.
3. Endodontic treatment has a high degree of success (approximately 90-95%). As with any medical or dental treatment however, this treatment has no guarantee of success for any length of time. Teeth with previous root canal treatment tend to have a lower success rate.
4. Accurate and complete disclosure of medical information is necessary for proper diagnosis, and to help prevent unnecessary complications during your treatment.
5. The most common complications with root canal therapy include but are not limited to:

- Continued infection requiring Endodontic (root canal) surgery or extraction of the tooth.
- Calcified canals or canals blocked by separated instruments requiring Endodontic (root canal) surgery or extraction of the tooth.
- Pain, requiring use of medication.
- Side effects and reactions to medication.
- Fracture (breaking) of the root or crown of the tooth during or after treatment. It is recommended that all posterior teeth be crowned following root canal treatment. If your tooth already has a crown, there is a chance it will need to be replaced due to decay or loss of structural support. Porcelain crowns are subject to breakage.
- Tenderness of the tooth following treatment due to possible complications with root canal treatment, gum disease, physical stress from chewing, or the degree of healing your body exhibits.

6. Other treatment choices include no treatment, waiting for more definite development of symptoms, and tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infections to other areas.
7. **Nitrous Oxide sedation is optional and charged separately. This is not covered by insurance and payment is the patients' responsibility.**
8. If you have any questions please ask!

"I have read and understand the above, and hereby consent to treatment."

Signature_____ Date_____

E-MAIL AUTHORIZATION

I give permission to Advanced Endodontics, P.C. to email (unencrypted) x-rays that may be taken back to my dentist. My treatment will NOT be altered if I do not give email authorization.

Signature_____**Date**_____

ADVANCED ENDODONTICS, P.C.

Surgical Post – Op Care

1. During the first day, apply an ice pack to your face over the affected area as much as possible. This will reduce swelling.

2. Do not attempt to examine the surgical site by pulling on your lip or cheek. This could loosen the sutures (i.e. stitches).

3. Eat soft foods (i.e. soup, mashed potatoes, Ensure, or Carnation Instant Breakfast). Avoid "sticky" foods like peanut butter or pizza. Also, avoid carbonated beverages.

4. DO NOT brush the teeth near the surgical site. Instead, rinse with 1 teaspoon of baking soda mixed with 8-10 oz. of water, twice daily (once in A.M. and once before bedtime). You may brush your remaining teeth.

5. Take any prescribed medications as directed.

6. If you were given a sedative before treatment today, do not drive a vehicle or operate any machinery for 24 hours.

7. Return in 5-7 days to our office for suture removal.

8. Three (200mg) Ibuprofen tablets (eg. Advil, Motrin IB) taken every 6-8 hours or two Aleve tablets taken every 12 hours for 3-5 days will help relieve inflammation and pain. Also, one extra strength Tylenol (500mg) tablet taken along with the Ibuprofen or Aleve will decrease pain.

* Mild swelling and discomfort is normal. If you have any questions or problems, please don't hesitate to call. If you call after regular office hours, our afterhours message will give you the phone number to reach Dr. Smith. (205) 933-8544

Root Canal Post – Op Instructions

For the first few days after treatment, your tooth may feel sensitive, especially if there was pain or infection before the procedure. Three (200mg) Ibuprofen tablets (eg. Advil, Motrin IB) taken every 6-8 hours or two Aleve tablets taken every 12 hours for 3 –5 days will help relieve this sensitivity. Also, one extra strength Tylenol (500mg) tablet taken along with the Ibuprofen or Aleve will dramatically decrease pain.

Your tooth may continue to feel slightly different from your other teeth for several weeks after your Endodontic treatment is completed. However, if you have severe pain or pressure that lasts more than a few days, call our office.

If your posterior tooth is not already covered with a crown, be very careful not to chew or bite on the treated tooth until you have had it restored by your general dentist.

If you were given a sedative before treatment today, do not drive a vehicle or operate any machinery for 24 hours.

James A. Smith, Jr. D.M.D.

(205) 933-8544