KEYSTONE ENDODONTICS

HEALTH QUESTIONNAIRE

Date**: _____/_____/_____** Name _____ ☐ Male ☐ Female

Date of Birth _____ / _____ / _____ Address _____

City _____State _____ Zip _____ Email address _____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____)_____

Place of Employment _____ SSN _____- _____ -_____

Emergency Contact _____Phone (_____) _____ Cell Phone (_____)_____

Whom may we thank for referring you? _____

Do any of the below conditions apply to you? (Please check yes or no)

	YES	NO		YES	NO
High Blood Pressure / Hypertension			Liver Disease		
Asthma			Bleeding Disorder		
Diabetes (Type _____)			Kidney Disease		
Rheumatic Fever			Organ Transplant		
Heart or Bypass Surgery			Cancer (Type _____)		
Angina Pectoris / Chest Pain			AIDS / HIV		
Heart Attack			Tuberculosis (TB)		
Prosthetic (artificial) Heart Valve			Epilepsy / Seizure		
Pacemaker / Implanted defibrillator			Artificial Joints		
Thyroid Disease / Goiter			Alcohol / Substance Abuse		
Vertigo			Allergy to Latex		
Hepatitis (Type _____)			Pregnant		
Renal Dialysis			Nursing		
Premedication			Other (specify) _____		

Medications/Reason_____

_____

Allergies_____

Hospitalizations/Surgeries _____

_____

Other Medical Concerns? _____

_____

Health Care Providers

Family Physician

Complete Name:_____

Telephone number:_____

General Dentist

Complete Name:_____

Telephone number:_____

Pharmacy

Name:_____

Number:_____

I certify that all the proceeding answers contained in this health history are complete and true. I understand that responding inaccurate could be dangerous to my health and cause adverse reactions during dental treatment. I understand that I am responsible for any errors or omissions that I may have made in completion of this form. It is my responsibility to inform the clinician of any health changes prior to services being rendered. I hereby authorize the Keystone Endodontics to release the necessary information to secure the payment of third party benefits. I authorize the use of this signature on all insurance submissions. I agree to be responsible for payment of all services rendered if not covered by the dental insurance.

_____ _____

Date Patient or Legal Guardian (Signature/Print Name)

INFORMED CONSENT FOR ROOT CANAL TREATMENT OR RETREATMENT

We would like our patients to be informed about the various procedures involved in Endodontic therapy and have their consent before starting treatment. Endodontic (Root Canal) therapy is performed in order to save a tooth which otherwise might need to be extracted. This is accomplished by conservative Root Canal treatment or, when needed, Endodontic Surgery. The following discusses the possible risks that can occur from or during Endodontic treatment, as well as risks involved with other treatment choices.

RISKS: Included, but not limited to, are complications from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics and injections, swelling, sensitivity, bleeding, pain, infection, numbness and a tingling sensation in the lip, tongue, chin, gums, cheeks and teeth. These complications are transitory, but on infrequent occasions can be permanent. Other risks include reaction to injections, changes to occlusion (biting), jaw muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth, referred pain to ear, neck and head, nausea, vomiting, allergic reactions, delayed healing, sinus perforations and treatment failure.

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

MEDICATIONS: If needed, prescribed medications and drugs may cause drowsiness and lack of awareness and coordination, which can be influenced by the use of alcohol, tranquilizers, sedatives and other drugs. It is not advisable to operate any vehicle or hazardous device until recovered from the effects.

CONSENT: I, the undersigned, am the patient (parent or guardian of minor patient) and I consent to the performing of procedures deemed necessary or advisable in the opinion of the Doctor. I understand the importance of giving a truthful health history to assist the Doctor in providing the best care possible. I also understand that upon completion of the Root Canal Therapy in this office, I shall return to my General Dentist for permanent restoration of the tooth involved. The fee for the final restoration is a separate fee charged by my General Dentist and is not included in the Root Canal fee. Failure to follow-up with the final restoration in a timely manner may result in failure of the Root Canal.

INCOMPLETE ENDODONTIC PROCEDURE: I understand that sometimes Root Canal Therapy/Retreatment is started, but during the procedure the doctor determines that the tooth cannot be saved. In those circumstances, you will not be charged the full cost of a Root Canal or Retreatment. However, there is a charge for the services already rendered. This is called "Incomplete Endodontic Therapy".

I understand that Root Canal Therapy is a biological procedure in an attempt to save a tooth that may otherwise require extraction. Although Root Canal Therapy has a high degree of success, it cannot be guaranteed. Successful completion of the Root Canal treatment does not prevent future decay or fracture. Occasionally, a tooth that has had Root Canal Therapy may require treatment, surgery or even extraction.

I understand that it is imperative and my responsibility that once the root canal is completed, I will need to follow up with my general dentist within one month to have a permanent filling, or crown (cap) placed.

_____ _____

Patient (Guardian) Signature/Print Name Date

_____ _____

Witness Signature/Print Name Date

Internal Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your protected medical information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., general dentist, oral surgeon, etc.) in connection with our rendering dental treatment to you (i.e. to determine the results of treatment, biopsy, surgery, etc.);
- To third party payers or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e. State Dental Boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment;
  and/or
- To other patients and third parties who may overhear conversations about your treatment, scheduling, etc.
- To your family and close friends involved in your treatment, and/or,
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

Persons authorized to speak with us:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

PATIENT ACKNOWLEDGMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice

_____
Patient Signature or Legal/ Guardian Print Name

_____
Date

Financial Policy

Thank you for choosing Keystone Endodontics as your dental specialty care provider. The following information describes our Financial Policy. Our primary goal is that you receive the optimal treatments needed to restore and maintain your dental health. Therefore if you have any questions about our financial policy, please do not hesitate to ask.

Payments: Unless other arrangements are approved by us in writing, the balance on your account is due and payable when services are rendered.

Dental Insurance: Payment in full is required at the time of service if we do not participate with your insurance. Dental insurance is a contract between you, your employer and your insurance company. We are NOT a party to this contract unless your insurance is through Aetna PPO and DMO, Ameritas, Assurant, Blue Cross Dental, Cigna PPO, Delta Dental PPO, Dentemax, Fidelio, GEHA, Guardian, LPMA. MetLife, Principal, and United Concordia. *If you have one of these policies, we ask that you pay your estimated portion at the time of your appointment.* For all other insurances, full payment is due at the time of the visit and as a courtesy to you, we will submit a claim on behalf to your insurance company and they *will provide reimbursement directly to you.*

IMPORTANT: Although we may estimate what your insurance may pay, it is the insurance company that makes the final determination of your eligibility and payment received. Payment from your insurance is never a guaranteed. We recommend that you understand your insurance policy; its limitations and benefits.

Please initial that you have read and understand the above statement _____.

Missed Appointment Fee: We make every effort to schedule appointments at your convenience and also confirm your appointment in advance. We do require at least 24 hours notice (one business day) if you are unable to keep your appointment. If you fail to make your appointment you will be charged $50.00 cancellation fee. This fee must be paid before another appointment is scheduled.

Please initial that you have read and understand the above statement _____.

Payment Options:

- You may choose to pay by cash, check, or credit card.
- We accept Visa, MasterCard, and Discover.
- We also participate with Care Credit. They offer several financing options, some of which are interest free.

Past Due Accounts: Any accounts over 90 days are automatically referred to a collection agency or reported as delinquent to the credit bureau. You agree to pay all costs which are incurred as a result of these actions. Accounts over 30 days will incur an 18% monthly finance charge unless other arrangements have been made.

Returned Checks: There is a $30.00 fee for any checks returned from the bank.

By signing this agreement, you understand and agree to all the terms and conditions contained herein and realize this agreement will be in full force. All questions were answered to your satisfaction.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to call us so that we can assist you in the management of your account.

Again, thank you for choosing Keystone Endodontics for your dental care. We appreciate your confidence in us and the opportunity to serve you.

Name of person Responsible for Account: _____

Relationship: self _____ parent _____

Signature: _____ Print Name: _____ Date: ____/____/____

Staff Signature: _____ Print Name: _____ Date ____/____/____