KEYSTONE ENDODONTICS

HEALTH QUESTIONNAIRE

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

Date of Birth _____ / _____ / _____ Address _____

City _____State _____ Zip _____ Email address _____

Best Phone Number to Reach You: Cell Phone _____ Home Phone _____

Place of Employment _____ SSN _____- _____ -_____

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

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		
Heart or Bypass Surgery			Organ Transplant		
Angina Pectoris / Chest Pain			Cancer (Type _____)		
Heart Attack			AIDS / HIV		
Prosthetic (artificial) Heart Valve			Tuberculosis (TB)		
Pacemaker / Implanted defibrillator			Epilepsy / Seizure		
Thyroid Disease / Goiter			Artificial Joints		
Vertigo			Alcohol / Substance Abuse		
Hepatitis (Type _____)			Allergy to Latex		
Renal Dialysis			Pregnant		
Premedication			Nursing		
			Other (specify) _____		

Medications _____

_____

Medicine Allergies _____

Hospitalizations/Surgeries _____

_____

Other Medical Concerns? _____

_____

General Dentist Name:_____Pharmacy:_____

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. Beginning on July 1, 2023, our dental office will no longer be participating with all dental insurance. Dental insurance is a contract between you, your employer and your insurance company, and never a guarantee of any payments. Full payment is due at the time of the visit and as a courtesy to you, we will help you submit a claim to your insurance company and they will provide reimbursement directly to you.

IMPORTANT: You are fully responsible for the balance at the time of service. Payment from your insurance is never a guarantee. It is the insurance company that makes the final determination of your eligibility and payment received. We recommend that you understand your insurance policy; its limitations and benefits.

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 hour 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.

Payment Options:

- You may choose to pay by cash, check, or credit card.
- We accept Visa, MasterCard, American Express and Discover.
- We also accept financing through 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.

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

Receipt of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices. (AVAILABLE UPON REQUEST)

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**
_____	_____
_____	_____
_____	_____

Our goal is to help you, not hurt you. We will proceed with this goal until there are unreasonable demands made, yelling and arguing, accusatory language or hostile behavior that makes anyone feel unsafe or that the trust in the relationship is gone. If this is encountered, we will be forced to dismiss you from our practice.

By initialing below, I acknowledge that I have read and understand this policy and agree to comply with these expectations while receiving care from this practice.

Patient Initials: _____ Date: _____

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.

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.

Signature: _____ Printed Name: _____ Date:_____

Staff Signature: _____ Printed Name: _____Date:_____