ESSENTIAL ENDODONTICS

Office Use Only

ID #_____

As a new patient, please take the time to fill out the information below to the best of your knowledge.
If you are unsure about a question, please let the front desk know.

Name: _____ DOB: _____ SSN: _____

Phone: Primary: _____ Secondary: _____ E-mail: _____

Mailing Address: _____
Street City State Zip

Employer: _____ Occupation: _____ How long? _____

Employer's Address: _____
City State Zip

Dental Insurance Information

Ins. Company Name: _____ Phone: _____

Insured's ID # or SSN: _____ Date of birth: ____/____/_____ Group#: _____

Insured's Name: _____ Relation: _____

Insured's Employer: _____

Dental History

Have we seen you before? Yes No

How did you hear about our office? _____

Are there any special dental considerations that we should be aware of? Yes No

Please Explain: _____

Family Physician Information

Name: _____

Phone: _____ Last checkup: _____

General Dentist Information

Name: _____

Phone: _____ Last checkup: _____

Emergency Contacts

Name: _____

Phone: _____ Relationship: _____

Name: _____

Phone: _____ Relationship: _____

Allergies

Please circle Y for yes or N for no

Y	N	Penicillin	Y	N	Nitrous
Y	N	Antibiotics	Y	N	Food: _____
Y	N	Aspirin	Y	N	Bleach
Y	N	Tylenol	Y	N	Iodine/Seafood
Y	N	Codeine	Y	N	Nitrile
Y	N	Narcotics	Y	N	EDTA
Y	N	Local Anesthetic	Y	N	Ethanol
Y	N	Latex	Y	N	Gutta-percha
Y	N	Ibuprofen	Y	N	Valium/Tranquil.
Y	N	Sulfa/Sulfides	Other: _____		

Medical History

Do you or have you had any of the following?

Please circle Y for yes or N for no

Y N Current Medical Treatment
Y N Prev. Endocarditis (heart)
Y N High Blood Pressure
Y N Respiratory/Asthma
Last Asthma Attack: _____
Y N Rheumatic Fever
Y N Heart Attack
When: _____
Y N Immunocompromised
Y N Anemia/Bleeding
Y N Diabetes/Kidney
Y N Herpes
Y N Thyroid/Hormonal

Y N Hypoglycemia
Y N Tobacco Use
Y N Shortness of Breath
Y N Cancer
Type:_____
Y N Tuberculosis
Y N Fatigue
Y N Swelling
Y N HIV/AIDS
Y N Hepatitis
Y N Ulcers/Digestive
Y N Migraine/Headache
Y N Glaucoma/Visual

Y N Epilepsy/Fainting
Last Episode: _____
Y N Mental/Neural
Y N Tumor/Neoplasms
Y N Alcoholism/Addiction
Y N Infectious Diseases
Type: _____
Y N Venereal Diseases
Y N Psychiatric Care
For: _____
Y N TMJ
Y N Heart Disease
Y N Heart Murmur/Defect

Y N Pacemaker
When Placed: _____
Y N Irregular Heart Beat
Y N Stroke
When: _____
Y N Prosthetic Implant
Y N Any Transplant
Type: _____
Y N Joint Replacement
Y N Arthritis
Y N Sleep Apnea
Other_____
_____

For Women:

Date of last menstrual cycle: _____
Are you nursing? ☐ No ☐ Yes
Is there any chance that you may be pregnant? ☐ No ☐ Yes

Are you pregnant? ☐ No ☐ Yes/How far along? _____
On birth control? ☐ No ☐ Yes

Surgical History

If you have had any surgeries, please list what they were and the date below:

Type _____Date _____
Type _____Date _____
Type _____Date _____
Type _____Date _____

Were there any complications from the surgery? Explain.

_____
_____
_____

Any other conditions you would like us to be aware of:

_____
_____
_____
_____
_____

Medications

Please list all medications you are currently taking and what condition it is for. Please use the back of this page if needed.

Name of Prescription	Condition

Are you currently or have you ever taken bisphosphonates (To treat osteoporosis and some forms of cancer)? (Circle one) Yes No

I have read and answered the above questions to the best of my knowledge and understand the importance of a truthful health history to assist the doctor in providing the best care possible.

1st Visit: Patient Signed: _____ Date: _____

Doctor Signed: _____ Date: _____

2nd Visit: Patient Signed: _____ Date: _____

Doctor Signed: _____ Date: _____

3rd Visit: Patient Signed: _____ Date: _____

Doctor Signed: _____ Date: _____

We accept Cash, Check, All Major Credit Cards and Care Credit.

Financial Agreement

1. I, _____, understand that my insurance coverage is an agreement between myself or the primary policy holder and the insurance company.
2. Essential Endodontics, P.A., Chris Yelton, D.D.S./Obadah Attar, B.D.S. DScD/Jae Ha Jung, D.D.S./Alex Fitzhugh, D.D.S./Jeffrey L. Saunders, D.D.S are third parties to this agreement. Essential Endodontics, P.A. may accept co-assignment of my benefits where applicable.
3. The amount of insurance coverage **estimated** for treatment at Essential Endodontics, P.A., is based on information I have provided and other information obtained directly from the insurance company, which may result to be inaccurate in part or entirely.
4. By signing this agreement, I represent that I will be financially responsible for any and all portions of my balance not received from my insurance company.
5. I agree to **pay my portion of today's treatment fees in full**, unless a payment plan has been agreed upon.
6. I agree that if I become **delinquent in a payment plan** established with Essential Endodontics, P.A. that I will be billed for the entire remaining balance and will be expected to pay in full immediately.
7. I agree to pay a finance charge of 2% per month for any balance not received in full within 60 days of this signed agreement. The full APR is 24%. This is effective as of February 1, 2010.
8. I agree to pay **a $35 charge** for any checks returned from my bank for any reason.
9. I agree to **pay all of the diagnostic charges** today (normally $165) if they are not covered by insurance. We will courtesy file to your insurance, and if they end up covering more than estimated we will send you a reimbursement check.
10. I understand that if I do not contact the office ahead of missing an appointment (i.e.., 24 hours advance notice unless it's an emergency), I will be responsible for a **$100 missed appointment charge.**
11. I understand that if my account remains unresolved after 60 days that Essential Endodontics, P.A., Chris Yelton, D.D. S./ Obadah Attar, B.D.S. DScD/ Jae Ha Jung, D.D.S./Alex Fitzhugh, D.D.S./Jeffrey L. Saunders, D.D.S. will send me to **small claims court**. I will then be responsible for all court fees that Essential Endodontics, P.A. will incur.
12. I understand that a **collections agency** may also be used instead of small claims court. This is dependent on the amount due to Essential Endodontics, P.A.
13. Essential Endodontics, P.A. files and processes insurance claims for our patients as a courtesy and is a third party in the contractual agreement between the patient and their insurance company. After 60 days post-treatment all unpaid balances including pending insurance claims and potential payments will become due immediately and the patient will be responsible for paying the unpaid balance in full.

NOTE TO THOSE NEEDING A PAYMENT PLAN:

We **require** debit/credit card information or bank account information for creating a payment plan. This allows us to automatically debit an agreed upon amount at an agreed upon time. If your card is declined, we will run the card everyday for any amount, up to the agreed amount. More details regarding the payment plan will be found on your payment/treatment plan sheet. Finance charges do apply. Please see line 7 for details.

Any bank charges associated with stop payments, insufficient funds, etc., will be added to your account.

_____ _____

Signature of Patient or Responsible Party Date

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY DENTAL APPOINTMENTS VIA:

- ▫ Cell Phone
- ▫ Home Phone
- ▫ Work Phone
- ▫ Text Message to my Cell Phone
- ▫ Email

I AUTHORIZE INFORMATION ABOUT MY DENTAL HEALTH TO BE CONVEYED VIA:

- ▫ Message on Cell Phone
- ▫ Message on Home Phone
- ▫ Message on Work Phone
- ▫ Text Message
- ▫ Email
- ▫ In-Person
- ▫ Any of the above

(Initial one)

_____ I agree that the dental practice may communicate with me electronically at the email address I provide and I am responsible for providing the dental practice any updates to my email address.
I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

_____ I do NOT give consent for the dental practice to communicate with me electronically.

To respect the privacy of our patients it is Essential Endodontics's policy that there is no photography permitted in the office. Thank you for your cooperation and understanding.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or guardian's) signature on this Acknowledgement but did not because:

- ▫ It was an emergency treatment
- ▫ I could not communicate with the patient
- ▫ The patient refused to sign
- ▫ Other (Please describe): _____

_____
Signature of Privacy Officer Only

ESSENTIAL ENDODONTICS

Acknowledgement of Receipt
Consent to Use and Disclosure of Protected Health Information

Notice of Privacy Practices

Review our Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may choose to review the Notice prior to signing this consent. By signing below, you acknowledge that we have given you a copy of our Notice of Privacy Practices.

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by our practice or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information.
Our office may or may not agree to restrict the use or disclosure of your Protected Health Information.
If we agree to your request, the restriction will be binding with our office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature

Date Time

Print Patient's Full Name

Witness Signature

Date Time

ESSENTIAL ENDODONTICS

2017 SAFELOCK CERTIFIED® WE KEEP PATIENT INFORMATION PRIVATE FROM SMART TRAINING

Patient Authorization
Release of Protected Health Information Records

Information to Be Released

Information covered by this authorization includes: _____

_____

Release of Records

The information listed above will be released to:

_____

Name of person, organization and address or fax number to which records should be sent - Please double-check fax number for accuracy

_____

Purpose of this Release

☐ For treatment at the facility to which records are sent ☐ Other reason _____

The Protected Health Information specified in this Release will be used solely for the purposes of treatment, payment and healthcare operations. Our facility complies with all applicable Federal and State privacy laws.

By my signature below I give permission to release the specified information.

Patient or Legally Authorized Individual Signature

Date Time

Print Patient's Full Name _____

Witness Signature

Date Time