PATIENT INFORMATION

Name: _____ Nickname: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home phone: (_____)_____ Work phone (_____)_____

Cell phone: (_____)_____ E-Mail address: _____

Social Security Number: _____ Date of birth: _____

Marital status: _____ Referred by Dr: _____

Employed by:_____ Occupation: _____

Employer's address: _____

City: _____ State:_____ Zip Code: _____

If full time student, Name of school: _____

Payment for patient's portion of today's services will be made by:

Cash_____ Check_____ VISA_____ MASTERCARD_____ DISCOVER____

DENTAL Insurance Information:

NO Insurance:_____

Primary Insurance:

Ins. Co. name_____

Address: _____

City: _____ State: _____ Zip:_____

Phone: (_____)_____

Name of subscriber: _____

Subscriber # _____ Group # _____

Secondary Insurance: (complete only if applicable)

Ins. Co. name: _____

Address: _____

City: _____ State:_____ Zip: _____

Phone: (_____)_____

Name of subscriber: _____

Subscriber # _____ Group # _____

PLEASE SIGN THE FOLLOWING TWO (2) RELEASES FOR BILLING INSURANCE:

Assignment of Benefits:

I hereby authorize payment directly to the Provider for services rendered.

_____

Patient, Parent or Guarantor's Signature

Release of Information:

I hereby authorize the release of any dental information necessary to process this claim.

_____

Patient, Parent or Guarantor's Signature

Patient's Spouse or Parent(s):

(Complete only if patient is NOT insurance subscriber and/or is a dependent child)

Name: _____

Address (if different): _____

City: _____ State: _____ Zip code: _____

Date of birth:_____ Social Security Number: _____

Employed by:_____

Employer's address: _____

City: _____ State: _____ Zip code: _____

Updates: (initials & date)_____ _____ _____ _____

PATIENT'S GENERAL MEDICAL INFORMATION

Patient's Name: _____ **Age:** _____

Medical Physician's Name: _____ **Address:** _____
City & State Only

Please list any serious illnesses or major surgeries (last 10 yrs): _____

_____

Describe any current medical treatment: _____

_____

List any medications, drugs or pills that you currently take: _____

_____

Please circle any of the following conditions you have experienced:

Glaucoma	Hives	Liver Disease	Nervous or Mental Disorder
Heart Disease	Chemotherapy	Hay Fever	Gastro-Intestional Disease
Rheumatic Fever*	Cancer	Thyroid Disease	High Blood Pressure
Heart Murmur*	Stomach Ulcer	Radiation Therapy	Low Blood Pressure
Lung Disease	Diabetes	Hepatitis, Type:_____	Chronic Sinus Condition
Blood Disease	Epilepsy	Kidney Disease	Artificial Joint Replacement*
Asthma	Arthritis	Lupus	AIDS or AIDS Complex

*Have you been told by your physician that you need premedication (antibiotic) before dental treatment? **Yes :** ____ **No:** ____

Allergies:

(Please read each question carefully before answering.)

Are you allergic to Aspirin?	**Yes :** ____	**No:** ____
Are you allergic to Penicillin?	**Yes :** ____	**No:** ____
Are you allergic to Latex (dental gloves)?	**Yes :** ____	**No:** ____

Have you ever had any reaction to local anesthetic? Describe: _____
Please list anything else to which you are allergic: _____

_____

Please describe any adverse effects you have had from taking any drug, medication, antibiotic or anesthetic:

_____

General Information:

Can you walk up a flight of stairs without getting out of breath or having chest pains?	Yes : ____	No: ____
Are you on a medically supervised diet? Describe: _____	Yes : ____	No: ____
Do you bruise easily?	Yes : ____	No: ____
Do you bleed abnormally? Describe: _____	Yes : ____	No: ____
Is this treatment for injuries sustained in an accident?	Yes : ____	No: ____
Type of accident: _____		
Date of Accident: _____		

Women Only: (For men & children, continue below)

Are you or may you be pregnant? Number of Weeks:_____	Yes : ____	No: ____
Are you nursing a baby? If yes, how old is the baby? _____	Yes : ____	No: ____

The above information is true and correct to the best of my knowledge. I will inform the doctor of any changes in my health or medications. I consent to be examined and to have x-rays taken of my teeth if needed.

Signed: _____ **Date:** _____
(Patient, Parent or Guarantor)

Updates: (initial & date) _____ _____ _____ _____

LAWRENCE ENDODONTICS, PA
4830 Quail Crest Place
Lawrence, Kansas 66049
785-843-8610

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Lawrence Endodontics, P.A. to use and/or disclose certain protected health information (PHI) about me to the following family member(s) and/or friends: **Please indicate relationship and any necessary telephone #'s.**

1) _____ 2)_____
3)_____ 4) _____
5)_____ 6)_____

This authorization/disclosure is provided so that I can make an informed decision whether to allow release of information. This authorization permits Lawrence Endodontics to use and/or disclose any individually identifiable health information about me pertaining to my treatment or to obtain payment for the services provided me. In addition, I can be contacted at the following places and receive messages for the following purposes: **Indicate by Y (yes) or N (no) for ea tel #/email listed.**

Your Contact Numbers:	Appt Confirmation	Treatment	Financial/Accounting
Cell:_____	___	___	___
Home:_____	___	___	___
Work:_____	___	___	___
Email*:_____	___	___	___

* If I agree that the dental practice may communicate with me electronically at the above email address, I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I am responsible for providing any updates to my email address and I can withdraw my consent to electronic communication by calling: 785-843-8610. I also understand that this risk may also apply to unencrypted emails sent to any healthcare providers related to my treatment.

I was given an opportunity to read and/or take with me a written copy of Lawrence Endodontics' Notice of Privacy Practices. I do not have to sign this authorization in order to receive treatment from Lawrence Endodontics, PA. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My revocation must be submitted to the Privacy Officer at Lawrence Endodontics, P.A.

Signed by:_____ **Date:** _____

Please Print the following:

Patient's Name: _____

Parent/Legal Guardian (if applicable) : _____

TREATMENT and FINANCIAL CONSENT FORM

Treatment:

- I understand that root canal treatment and the alternative(s) to root canal treatment will be explained to me by my Endodontic Specialist at Lawrence Endodontics, PA prior to beginning any treatment.

- Possible risks and complications of root canal treatment include but are not limited to the following: pain; swelling of the gum, jaw or face; trismus (restricted jaw opening); temporary or permanent numbness of the gum, lip or face; infection of the jaw, face or other parts of the body; allergic or other serious or potentially life threatening adverse reactions to medications prescribed or materials used.

- In approximately 5-10% of cases, treatment does not succeed. If failure occurs, the treatment may have to be redone, root-end surgery may be required or the tooth may have to be extracted (taken out.) Small instruments may break during treatment, which may be left in the root or jaw or require surgery for removal. The root may be perforated with instruments which may require additional surgical corrective treatment or result in premature tooth loss or extraction. The tooth may be lost to progressive periodontal (gum) disease in the surrounding area. Another undiscovered tooth in the area may also require root canal treatment. The root of the tooth may break during or after treatment and the tooth will have to be extracted.

- I agree to take all medications prescribed and to promptly report any problems to the office by calling 785-843-8610.

- I understand that after root canal treatment my tooth will be brittle and must be protected against fracture by a crown (cap) or filling by my general dentist. If this is not done, there is a strong possibility that I will lose the tooth. If my Endodontic Specialist recommends, I agree to return in six (6) months for a recall visit so that the doctor can evaluate the root canal treatment and I agree to follow his recommendations at that time.

Financial:

- I understand that if I **do not** have dental insurance that I am responsible for **payment in full** at **time of treatment.** If I **do** have dental insurance, I am responsible for my **estimated portion in full** at **time of treatment.**

- No warranty or guarantee of success has been or can be given in root canal treatment. I acknowledge full responsibility for the payment of such services. I agree that no refund is due if the tooth is lost prematurely or if other complications occur.

- While the staff will make their best attempt to get accurate benefit information, I understand that any balance due after insurance pays (due to: under estimation, having met insurance plan maximum for year or for procedures not covered by insurance, etc) or for accounts for which insurance has not paid within 60 days of treatment, that this balance is my responsibility and is due in full **at that time. Effective, 7/1/2010, if balance is not paid within 90 days of service date, finance charges will accrue with an annual rate of 12% compounded monthly.**

- **I agree to pay fees or interest charges incurred if my account is referred to a collection agency or attorney for collections.**

I have read and fully understand the above statements on this "Treatment and Financial Consent" form. I hereby consent to the required treatment to be performed by my Endodontic Specialist at Lawrence Endodontics, PA and to these financial stipulations.

Signed:_____ **Date:**_____

(Patient, Parent or Guardian)

Updates:_____ _____ _____ _____