

PATIENT INFORMATION

Name: _____ Nickname: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Date of Birth: _____

Home# : _____ Cell# : _____ Work#: _____

SSN _____ - _____ - _____ Email: _____

Employer: _____ Occupation: _____

PAYMENT FOR TODAY'S SERVICES MADE BY: Cash _____ Credit Card _____ CareCredit _____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance: _____ ID/SSN# _____

Group Number : _____ Policy Holder Name: _____ DOB: _____

Secondary Dental Insurance: _____ ID/SSN# _____

Group Number : _____ Policy Holder Name: _____ DOB: _____

PATIENT'S SPOUSE OR PARENT INFO:

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

Name: _____ Cell Number: _____

Address (if different than above): _____

City: _____ State: _____ Zip: _____

DOB: _____ SSN: _____

Employer: _____

x _____
(Patient or Guarantor Signature)

x _____
(Date)

UPDATES: Initials and Date _____

GENERAL MEDICAL INFORMATION

Patient Name: _____ Age: _____

Physician Name: _____ Referring Dentist: _____

Please list any serious illnesses / major surgeries in the last 10 years: _____

Describe any current medical treatment: _____

List any medications or supplements 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-Intestinal 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 antibiotic premedication before dental treatment for joint replacement or heart condition?
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? Yes: _____ No: _____

Please list anything else that you are allergic too: _____

Have you ever had a reaction to local anesthetic? _____

Please describe adverse effects to any medications, supplements or anesthesia _____

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? _____	Yes _____ No _____
Do you bruise easily?	Yes _____ No _____
Do you bleed abnormally? Describe: _____	Yes _____ No _____
Is this treatment for injuries sustained in an accident? If so type of accident and date of accident: _____	Yes _____ No _____

Are you pregnant? _____ If yes, how many weeks? _____ Are you nursing? _____ Baby's Age _____

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

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

UPDATES: _____
(Initial and Date)

KANSAS ENDODONTICS, LLC
4830 Quail Crest Place, Suite B
Lawrence, Kansas 66049
785-843-8610

By signing, I authorize Kansas Endodontics, LLC to use and/or disclose certain protected health information (PHI) about me to the following family member(s) and/or friends: Please indicate names, relationship and telephone numbers:

1. _____
2. _____
3. _____

This authorization/disclosure is provided so that I can make an informed decision whether to allow release of information. This authorization permits Kansas 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 circling Y or N for if we may use this contact method. May we text you? Y or N**

Contact Numbers/Email	Confirm Appointment	Discuss Treatment/Billing
Home: _____	Y or N	Y or N
Cell: _____	Y or N	Y or N
Work: _____	Y or N	Y or N
EMAIL: _____	Y or N	Y or N

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: 785-215-8441 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 Kansas Endodontics Notice of Privacy Practices. I do not have to sign this authorization in order to receive treatment from Kansas Endodontics, LLC 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 re-disclosure 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 Kansas Endodontics, LLC.

PLEASE PRINT THE FOLLOWING:

PATIENT NAME: _____

PARENT/LEGAL GUARDIAN: _____

(SIGNATURE)

(DATE)

TREATMENT AND FINANCIAL CONSENT FORM

- I understand that root canal treatment and the alternative(s) to root canal treatment will be explained to me by my specialist at Kansas Endodontics 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 785-215-8441 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 treating dentist 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 the doctor's recommendations at that time.

FINANCIAL:

- 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.

- 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. I also understand there is a \$40 returned check fee for any returned checks.

- While the staff will make their best attempt to get accurate benefit information, I understand that any balance due after my insurance has paid or if my insurance doesn't pay within 60 days of treatment, that this balance is my responsibility and is due immediately. We are in network with BCBS of Kansas (NOT PPO PLANS), Delta Dental and Aetna . We do not file workmans compensation claims or claims to medical insurance.

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

- 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 KANSAS ENDODONTICS and to these financial stipulations. I hereby authorize payment directly to the provider for services rendered and authorize the release of any information needed to process my dental claims.

(SIGNATURE)

(DATE)