Endodontic Associates of Alaska

800 E. Dimond Blvd. Ste. 3-600 Anchorage, AK 99515

Date: __________________

Patient Information

Name: ____ Nickname ____________________
Last First M.I.

☐ Male ☐ Female DOB: ________________ ☐ Child ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Mailing Address: ____
Street City State Zip

Physical Address: ____
Street City State Zip

Phone (H):______________________ (Wk):______________________ Ext: ________ (Cell):____________________

Soc. Sec. #: __________________ Drivers License #: __________________ Email: ____________________________

Employer Name: __________________________________ Occupation/Position: ______________________________

Referring Dentist: __________________________ Emergency Contact & #: ____________________________________

Spouse or Responsible Party Information (if different from patient)

Name: ____ Relationship to patient: ____________________________

DOB: ____________ Soc. Sec. #: __________________ Phone: (H) _______________ (Wk/Cell) __________________

Address, if different from above: ____
Street City State Zip Code

Insurance Information

If you would like our office to bill your insurance, Social Security or I.D. number and a credit card preauthorization form <u>must be completed</u>

Primary Dental Insurance

Insurance Co. ____________________________ Group # ________________ ID # ___________________________

Insurance Address ____ Insurance Phone # _______________________

Name of Policy Holder _____________________________ DOB: ____________ Soc. Sec. #: ______________________

Policy Holder's Employer ____

Secondary Dental Insurance

Insurance Co. ____________________________ Group # ________________ ID # ___________________________

Insurance Address ____ Insurance Phone # _______________________

Name of Policy Holder _____________________________ DOB: ____________ Soc. Sec. #: ______________________

Policy Holder's Employer ____

Updates (date & initial) ________________ ________________ ________________ ________________

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Health Information

What is your current dental problem? ______________________________

☐ YES ☐NO Are you in good health?

☐ YES ☐NO Are you currently undergoing medical treatment of any kind? If yes, please describe: ______________________________

______________________________ Physician: ______________________

☐ YES ☐NO **Are you allergic/sensitive to penicillin, latex or any other medication or material? If yes, please list;**

____

☐ YES ☐NO Do drugs make you feel nauseated?

☐ YES ☐NO Do you have dizziness or fainting spells?

☐ YES ☐NO Have you had any problems with previous dental treatment?

☐ YES ☐NO Have your teeth been difficult to numb in past?

☐ YES ☐NO Do you use alcohol regularly?

☐ YES ☐NO Do you use recreational drugs?

☐ YES ☐NO Are you taking any prescription medications? Please list: ______________________________

☐ YES ☐NO Are you subject to prolonged bleeding?

☐ YES ☐NO Have you ever had artificial prosthesis, hip replacement, heart valves, pacemaker, etc.? If yes, please list:

____

☐ YES ☐NO Does your jaw click or get out of joint?

☐ YES ☐NO Have you ever had periodontal (gum) treatment? When? ______________________________

☐ YES ☐NO Have you ever had root canal treatment? When? ______________________________

☐ YES ☐NO Female Patients: Are your pregnant? Month Due: ______________________________

☐ YES ☐NO Female Patients: Are you breastfeeding?

Have you had (circle all that apply)?

AIDS	Asthma	Frequent headaches	HIV	Stroke
Alcoholism	Bleeding disorders	Glaucoma	Kidney-bladder trouble	Tuberculosis
Drug dependence	Cancer	Heart murmur	Nervous disorders	Ulcers - Colitis
Allergies	Convulsions	Heart trouble	Psychiatric care	Viral infections
Anemia	Diabetes	Hepatitis	Rheumatic fever	X-ray treatment
Angina (chest pain)	Ear trouble	Herpes	Scarlet fever	
Arthritis	Epilepsy	High blood pressure	Sinus problems	

Do you take any of the following medications (circle all that apply)?

Antibiotics	Blood pressure medication	Glaucoma medication	Sedative
Anticoagulants	Cortisone / steroids	Hormones / birth control	Thyroid medication
Anticonvulsants	Decongestants	Insulin / diabetes medication	Tranquilizers
Arthritis medication	Digitalis / heart medication	Iron / anemia medication	Other ____________
Aspirin products	Diuretics	Nitroglycerine	Other ____________
Asthma medications	Emphysema medication	Pain medication	Other ____________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment.

X______________________________ ______________________________ ______________

Signature of patient or legal guardian **Printed name** **Date**

Updates **(date & initial)** ______________ ______________ ______________ ______________

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Acknowledgment and Consent for Use and Disclosure of Health Information

Section A**: Patient Giving Consent**

Name: ____

Date of Birth: ______________________________Social Security Number: _________________________________

Section B: **PLEASE READ THE FOLLOWING STATEMENT CAREFULLY:**

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we make of your protected health information, and other important matters about your protected health information. A copy of our notice accompanies this consent.

We reserve the right to change our privacy as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes apply to any of your protected health information what we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Contact Person: Darin Anderson D.M.D.
Contact Number: (907)349-3636
Address: 800 E. Dimond Blvd. Ste. 3-600, Anchorage, AK 99515

RIGHT TO REVOKE: You will have the right to revoke this consent at any time by submitting written notice of revocation to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance of this consent before we received you revocation, and that we may decline to treat you or to continue treating you if you revoke consent.

I, ____, have had the full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I also acknowledge that I have received a copy of your Notice of Privacy Practices. I also understand that by signing this form, I am giving my consent for your use and disclosure of my protected health information to carry out treatment activities and health care operations.

SIGNATURE:

X____Date:____________________________

If this consent is signed by personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____________________________Relationship:_____________________

OFFICE USE ONLY

We attempted to obtain written consent and acknowledgement from the patient regarding our Privacy Policy but unable to because:

- ○ Individual refused to sign.
- ○ Communication barriers prohibited obtaining signature.
- ○ An emergency prevented us from obtaining signature.
- ○ Other:____

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REVOCATION OF CONSENT:

I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written Notice of Revocation. I also understand that you may decline to treat or continue to treat me after I revoke my consent.

Signature X____Date:___________________________

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Payment Options/Insurance

Thank you for selecting Endodontic Associates of Alaska for your endodontic treatment. Please review and choose one of our payment options below. Please speak to our receptionist ***prior*** to your treatment if you have any questions about your payment options.

☐ **Cash** ☐ **Debit** ☐ **Visa** ☐ **MasterCard**

*** INSURANCE IS BILLED AS A COURTESY. YOU ARE STILL RESPONSIBLE FOR THE FULL AMOUNT OF YOUR BILL. If you are asking our office to submit your insurance claim you are required to pay your ESTIMATED co-payment and any deductibles related to your insurance policy. We ask that you provide us with your credit or debit card information and preauthorization to bill any outstanding balance on your account to this card after your insurance payment is received or when your account reaches 60 days (whichever is earlier). Your receipt will be mailed to the address we have on file. If payment from your insurance company results in an overpayment we will promptly refund the difference to the appropriate party.**

I acknowledge full responsibility for the payment of such services and agree to pay for them, in full, at or before completion unless other specific arrangements have been made with the collections manager in advance. I understand that any prices quoted to me for my root canal treatment are an *estimate* and may change due to biological and or anatomical circumstances not usually detectable until the internal anatomy, etc. of my tooth has been accessed and evaluated by the doctor.
I authorize my insurance carrier to issue the dental benefits of my plan directly to this dental office. I also authorize the release of any information necessary to process my dental insurance. I understand that my insurance coverage is a contract between my insurance carrier and myself and that Endodontic Associates of Alaska is not a party to this contract. Endodontic Associates of Alaska therefore cannot become involved nor represent me in claim disputes with my insurance carrier. Situations such as, but not limited to, claim denials and "usual and customary" disputes are my responsibility to resolve with my insurance carrier. If a dispute or denial occurs I agree to pay the balance of my account in full and contact my insurance carrier personally to resolve the dispute or denial.
I understand that a billing charge of 10.5% (APR) is assessed on all accounts over 60 days regardless of their insurance billing status. I agree to inform Endodontic Associates of Alaska in writing of any change in my billing or mailing address as long as I have an outstanding balance. I accept responsibility for all costs incurred by Endodontic Associates of Alaska in collecting my debt owed to them, including but not limited to non-sufficient fund fees, stop payment fees, attorney fees, skip tracing fees and collection fees.

X____ ____________________

Patient Signature or Guardian if patient is under 18 Date

Credit/Debit Card Information and Preauthorization

☐ **I authorize Endodontic Associates of Alaska to charge the outstanding balance of my account after my insurance payment is received or when my account reaches 60 days (whichever is earlier).**

☐ **I authorize recurring charges of $_________._____ on the *first half* or *second half* of the following months (not to exceed 60 days):**

____________________ ____________________ ____________________

____

CARDHOLDER NAME EXACTLY AS IT APPEARS ON THE CARD

____ ________________

CREDIT CARD NUMBER EXP. DATE

X____ ________________

CARDHOLDER SIGNATURE OR AUTHORIZED REPRESENATIVE DATE

AN IMPRINT OF THE CREDIT/DEBIT CARD SHOULD ACCOMPANY THIS FORM

Updates **(date & initial)** ________________ ________________ ________________ ________________

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Informed Consent for Root Canal Treatment

Definition of Endodontics Specialist and Root Canal Treatment

Endodontists are dental specialist with advanced training in endodontic (root canal treatment) procedures. They provide only endodontic service in their offices and perform routine as well as difficult and very complex procedures, including endodontic surgery. Endodontist are also experienced in finding the cause of oral and facial pain that has been difficult to diagnose.

Root canal treatment requires removing the nerve and other tissues (called the pulp) from inside the tooth and its root(s). This is done by first making an opening through the chewing surface of the tooth to gain access to the tooth's pulp. The contents of the root canals are removed and the canals are cleaned and shaped. The canals are then filled and sealed with a biologically compatible material called gutta percha. After root canal treatment, a temporary filling is placed and the tooth will then require timely placement of the final restoration (permanent filling and crown), to return it to proper function.

The recommendation for treatment is based on visual and radiographic examination, as well as other diagnostic tests performed by the Endodontist. Root canal treatment is often necessary because of pain, infection, decay, broken/fractured teeth as well as other extenuating factors. The intended benefit of root canal treatment is to relieve current symptoms and/or to permit the continuation of any additional treatment the general dentist has proposed. Root canal treatment allows for the retention of the tooth and its root in the mouth, thereby permitting the tooth to be restored to function.

Treatment provided in this practice is performed in accordance with accepted clinical methods as described for both the American Associates of Endodnotics and the American Dental Association. This procedure will require administration of local anesthetic agents, as well as placement of a rubber dam to maintain a clean environment during treatment. A number of radiographs will be necessary to complete the root canal procedure and will vary depending upon the complexity of the case. Additionally, the number of office visits required to complete treatment depends upon the diagnosis and complexity of each tooth; however, routine root canal treatment can generally be completed in one or two appointments.

Informed Consent

I understand that root canal treatment can have a very high degree of clinical success (85-95% of routine cases are successful); however, as with any branch of medicine or dentistry, no guarantee of successful treatment can be given or implied. Although clinical success of routine procedures is very high, there are certain inherent and potential risks associated with root canal treatment that can lower the final prognosis. While infrequent, such complications include but are not limited to:

- Curved canals/roots.
- Calcifications in the root space.
- Fractures of the tooth's chewing surface or root, including the fracture of porcelain on a crown.
- Infection, swelling or discoloration of adjacent tissue.
- Discomfort during or following treatment.
- Injury to hard or soft tissue adjacent to the tooth.
- Sinus perforation.
- Nerve disturbances or damage, such a temporary or permanent numbness itching, burning or tingling of the lip, tongue, chin teeth and/or mouth tissues.
- Procedural difficulties such as the separation of instruments in the root canal space, extrusion of material beyond the tip of the root, and perforations of the crown or root while locating canal space. This could result in need of oral surgery (apicoectomy or perforation repair) to address the problem, and may in some instances require removal of the tooth.

I understand that root canal treatment may not relieve my symptoms, and that treatment may not be successful for unexplainable reasons. If treatment is unsuccessful, other procedures, including re-treatment of the root canal and/or oral surgery, may be necessary to retain the tooth and, on some occasions, the tooth may require extraction.

I understand that once root canal treatment is completed, I must return to my dentist in a timely manner to begin the next step in treatment. If I fail to return to my dentist to have the tooth restored, I risk a failure of the root canal treatment, decay, infection, and tooth fracture, which could result in loss of the tooth.

Before proceeding with treatment, I will ask any questions that I may feel are necessary to understand the risks, benefits and alternatives associated with this procedure.

Signed____Date_________________

Patient, Parent or Legal Guardian (Must be 18 years of age or older)