

REGISTRATION

Patient Name _____
Home Address _____
City _____ State ____ Zip _____
Home Telephone # _____
Cell Phone # _____
Email Address _____
Emergency Contact Name _____
Relationship to Patient _____
Patient Soc. Sec # _____ DOB _____
Referring Dentist _____
Medical Doctor _____
Pharmacy Name/Location _____
Pharmacy Telephone # _____
Employer's Name _____
Employer's Address _____
City _____ State ____ Zip _____
Employer's Telephone # _____

Primary Dental Insurance

Ins. Co. Name _____
Ins. Co. Address _____
Group # (Plan, Local or Policy #): _____
Insured's Name _____
Relation _____
Insured's Birthdate _____
Insured's SS# / ID# _____
Insured's Employer _____

Secondary Dental Insurance

Ins. Co. Name _____
Ins. Co. Address _____
Group # (Plan, Local or Policy #): _____
Insured's Name _____
Relation _____
Insured's Birthdate _____
Insured's SS# / ID# _____
Insured's Employer _____

Person Financially Responsible for this Account

Name _____ Soc. Sec # _____ DOB _____

Fees are due upon completion.

Which of the following methods of payment will you be using if treatment is completed today?

Cash _____ Personal Check _____ Credit Card: Type _____ CARE CREDIT: _____

AVERAGE ENDODONTICS FEES

Anterior & Bicuspid Teeth \$1015 - \$1175 • Molar Teeth \$1445 • Endodontic Surgery \$1325 - \$1855
Incomplete Root Canal \$500 • Retreatment \$1275 - \$1825

There may be an additional fee for treatment rendered under extraordinary circumstances (surgery, crowns, obstructions, retreatments)

IMPORTANT BILLING INFORMATION: PLEASE READ CAREFULLY THEN SIGN.

It is the Patient/Guardian's responsibility to be aware of their dental benefits (Plan Participation, Co-Pays, Deductibles, Eligible Waiting Period, Maximum Allowances, Lapses in Coverage, etc.)

If you are covered under dental insurance (medical insurance does not apply) our office will bill your insurance company for treatment(s) rendered. Generally, insurance companies process claims within a period of 4 weeks.

**At the time of treatment your ESTIMATED co-pays and deductibles will be collected.
Our office will then bill you for any remaining balance of your co-pays, deductibles and/or non covered services.**

There are instances where we expect payment in full at the time of treatment.

- A. If you do not have any dental insurance
- B. Your dental benefits are maxed out for the year
- C. Your insurance is a discounted fee plan
- D. Your insurance is a plan that our office is non-participating and they mail payments to patients directly.

If you have a previous balance, that balance must be paid in full before we can initiate further treatment.

First Visit:

Signature _____ Date _____

Follow Up Visits: Initial _____ Date _____ Initial _____ Date _____

HEALTH QUESTIONNAIRE

Drs. Initials _____ Date _____

Drs. Initials _____ Date _____

Drs. Initials _____ Date _____

Are you allergic to LATEX? YES / NO

Please list any Drug Allergies _____

Have you ever had any unusual reaction to: Aspirin, Codeine, Darvon, Local Anesthesia, Penicillin, or any other drug or medication? _____

Is there any reason that you are unable to take Ibuprofen, Motrin or Advil due to a medical condition

YES / NO / WHY? _____

Are you under a physician's care now? _____ If so, please give reason for treatment _____

List any medication, including all over the counter drugs, vitamins and supplements you are currently taking? _____

Please circle any illness you have ever had:

Allergies	COPD	Heart Attack (<i>Date</i> _____)
Rheumatic Fever	Sinus Trouble	Diabetes
Liver Disease	Venereal Disease	Glaucoma
Hepatitis	Cancer (<i>Describe</i>)	Stroke (<i>Date</i> _____)
Thyroid Disease	Radiation or Chemo	H.I.V. / Aids
Kidney Disease	Migraine / Headaches	Joint Replacement (<i>Describe</i>)
Lung Disease	Epilepsy	Asthma
Tuberculosis	Anemia	Ulcer
_____ Diagnosis ever been made	Heart Disease	Hypertension / Hypotension
_____ Persistent cough greater than 3 weeks	Heart Valve Replacement	Jaundice
_____ Cough that produces blood	Heart Valve Repair	Psychiatric
TMJ Disorder	Mitral Valve Prolapse	Autoimmune Disease
Night Appliance	Heart Murmur	Alcohol or Drug Addiction
	Arrythemia	

Are you currently under treatment for any of the above conditions? _____

Do you pre-medicate before dental treatment with antibiotics? _____

Did you pre-medicate before **TODAY'S** dental treatment with antibiotics? _____

Are you currently taking aspirin or blood thinning medication? _____

Are you currently taking, or have taken bisphosphonate medication (Fosamax, Actonel, Zometa, Aredia, Boniva, Skelid, Alendronate)? _____

Do you have a pacemaker? _____

Have you ever had trouble with prolonged bleeding after surgery? _____

Women: Are you pregnant? _____ If yes, what trimester _____

Is there any other information that should be known

About your health? _____

Signature _____ Date _____

I give authorization to release my records to any physician or dentist that I am referred to, for further treatment:

Signature _____ Date _____

Follow Up Visits: Initial _____ Date _____ Initial _____ Date _____

Drs. Initials _____ Date _____

Drs. Initials _____ Date _____

Drs. Initials _____ Date _____

Chester County Endodontics

Consent for Endodontic Treatment

Please review the following consent. You will be required to sign it prior to the initiation of treatment; however, it does not commit you to treatment.

This is my consent to the endodontic procedures indicated and any other procedures deemed necessary or advisable as a corollary to the planned endodontic therapy performed by any of the doctors employed by **Chester County Endodontics** and any assistant they may require. I agree to the use of local anesthesia, depending upon the judgment of the doctors. I understand the doctors will consult with me prior to administering any sedation and/or nitrous oxide analgesia. **Complications of root canal therapy and anesthesia may include swelling, pain, trismus (restricted jaw opening), infection, bleeding, sinus involvement, and numbness or tingling of the lip, gum or tongue, which rarely is protracted and even more rarely is permanent. I understand that it is my responsibility to report any symptoms to the doctors immediately.**

I understand that root canal therapy is a procedure to retain a tooth which may otherwise require extraction and that as a specialty practice, the office performs only endodontic therapy and associated surgery. Although root canal therapy has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery, or even extraction. Following treatment, the tooth may be brittle and subject to fracture. A restoration (filling), crown, and/or post and core will be necessary to restore the tooth function; this will be performed by my dentist. During treatment there is the possibility of instrument separation within the root canals, perforations (extra openings), damage to bridges, existing fillings, crowns or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals, and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when my tooth may not be amenable to endodontic treatment at all. Other treatment choices include no treatment, waiting for more definitive symptoms to develop, or tooth extraction. Risks involved in these choices might include but are not limited to pain, infection, swelling, loss of teeth, and infection to other areas.

At times, medication will be prescribed by the doctors. I understand that medications for discomfort and sedation may cause drowsiness which can be increased by the use of alcohol or other drugs. I am advised against operating any vehicle or hazardous devices while taking such medications. I further understand that certain medication may cause hives and intestinal problems and if any of these reactions occur, I am to call the doctors immediately. I understand that it is my responsibility to report any changes in my medical history to the doctors.

Patient's Name (please print) _____

Signature and Date _____

Guardian's Name (please print) _____

Signature and Date _____

Follow Up Visits: Initial _____ Date _____ Initial _____ Date _____

Follow Up Visits: Initial _____ Date _____ Initial _____ Date _____



Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this Acknowledgement

I, _____, have received a copy of this office's
Notice of Privacy Practices.

Print Name

Signature

Date

Follow Up Visits: Initial _____ Date _____ Initial _____ Date _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (*please specify*)

Milad Azadi, D.M.D.

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