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 <u>ESTIMATED</u> 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 _____

Drs. Initials_____ Date_____

Drs. Initials_____ Date_____

Drs. Initials_____ Date_____

HEALTH QUESTIONNAIRE

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
Rheumatic Fever
Liver Disease
Hepatitis
Thyroid Disease
Kidney Disease
Lung Disease
Tuberculosis
____ Diagnosis ever been made
____ Persistent cough greater than 3 weeks
____ Cough that produces blood
TMJ Disorder
Night Appliance

COPD
Sinus Trouble
Venereal Disease
Cancer *(Describe)*
Radiation or Chemo
Migraine / Headaches
Epilepsy
Anemia
Heart Disease
Heart Valve Replacement
Heart Valve Repair
Mitral Valve Prolapse
Heart Murmur
Arrythemia

Heart Attack *(Date_____)*
Diabetes
Glaucoma
Stroke *(Date_____)*
H.I.V. / Aids
Joint Replacement *(Describe)*
Asthma
Ulcer
Hypertension / Hypotension
Jaundice
Psychiatric
Autoimmune Disease
Alcohol or Drug Addiction

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

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

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

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 futher 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 _____

CHESTER COUNTY
ENDODONTICS

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.

404 McFarlan Road • Suite 302 • Kennett Square, PA 19348
610-925-3440 • Fax 610-925-3421
www.chestercoendo.com

Financial Agreement

I have read the informed consent on the reverse side and agree to treatment of tooth # _____. The fee for this service is $ _____.

We are participating with the following dental insurance carriers;

Aetna/Careington/Coventry, Delta Dental, Cigna, Guardian, Met Life, United Concordia's National Fee for Service Plan only, Sun Life, Dentemax, Dominion, Humana, Principal, United Healthcare PPO, DHA/Assurant, Lincoln Financial

*** I am financially responsible for any amount not covered by my dental insurance carrier, not to exclude any non-covered consultation fees.
(This may be due to yor deductible, a non-covered service, non-duplication clause, or your benefits may be maxed out for the year.)

( ) I have dental insurance and I agree to pay my estimated responsibility of $ _____ Today and understand that I may incurr additional costs as noted above. ***

( ) I do not have dental insurance and I understand my financial responsibility today.

All balances must be paid within 30 days from completion of treatment or receipt of insurance payment. We reserve the right to place any unpaid balance after 30 days on credit/debit card left on file and a receipt will be mailed to you. You will be charged 3% interest on unpaid balances after 90 days. We reserve the right to forward any unpaid accounts to the collection agency we are contracted with after 90 days.

I have read and agree to the polices of this office.

Patient Name: _____

Signature of Guarantor: _____

Date: _____