Patient Information & Payment Policy

FLATHEAD ENDODONTICS

Full Name _____
Last **First** **Preferred**

Mailing Address _____

_____
City **State** **ZIP Code**

Home Phone _____ **Cell Phone** _____

Email _____

SSN Number **(required if you have dental insurance)** _____

Birth Date _____ **Employer** _____

General Dentist: _____

We are pleased to welcome you to our office! New patients are always appreciated! Our Practice has grown as a result of its excellent relationship with our referring dentists and patients. In most situations, root canal treatment can be accomplished in one visit and our fees vary depending on which tooth is treated and the degree of difficulty.

Payment is due in full at the time treatment is provided. If you have dental insurance, we are happy to file with your carrier, **however we are NOT in network with any insurance carrier**. It is our policy to collect **50%** up front at the time of visit if we are submitting to your insurance. Balance will be due on receipt after insurance has paid. **WE DO NOT ACCEPT MEDICAID.** For your convenience, we accept Visa, MasterCard, Discover and American Express. We also offer financing through Care Credit. If approved, you will secure a 12 month no interest loan.

PREFERRED METHOD OF PAYMENT:

☐ **CASH** ☐ **CHECK** ☐ **CREDIT CARD*** ☐ **CARE CREDIT**

I, the undersigned, have read the above information and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even if I have dental insurance coverage, I am responsible for full payment of treatment provided. I also authorize the release of any dental information necessary to process the insurance claim.

Signature: _____ **Date:** _____
If you would like a cost estimate or have any concerns or questions, please notify **Deedra, Carol, or Megan** before seeing the doctor.

Medical History

Patient Name: _____ **Age**: _____

- Have you been under the care of medical doctor or hospitalized during the past two years? Yes No
- If yes, for what reason? _____
- Are you allergic to or made sick by penicillin, aspirin, codeine, or any other drugs or medications? Yes No
- If yes, please list: _____
- Have you ever had any excessive bleeding requiring special treatment? Yes No

Check any of the following which you have had or have at present:

☐ Heart Failure	☐ Shortness of Breath	☐ HIV Positive
☐ Heart Disease or Attack	☐ Emphysema	☐ Hepatitis A (infectious)
☐ Angina Pectoris (chest pain)	☐ Cough	☐ Hepatitis B (serum)
☐ High Blood Pressure	☐ Tuberculosis (TB)	☐ Liver Disease
☐ Heart Murmur	☐ Asthma	☐ Yellow Jaundice
☐ Rheumatic Fever	☐ Hay Fever	☐ Blood Transfusion
☐ Congenital Heart Lesions	☐ Sinus Trouble	☐ Drug Addiction
☐ Scarlet Fever	☐ Allergies or Hives	☐ Hemophilia
☐ Artificial Heart Valve	☐ Diabetes	☐ Cold Sores or Fever Blisters
☐ Heart Pacemaker	☐ Thyroid Disease	☐ Epilepsy or Seizures
☐ Heart Surgery	☐ X-ray or Cobalt Treatment	☐ Fainting or Dizzy Spells
☐ Artificial Joint	☐ Chemotherapy	☐ Nervousness (Excessive)
☐ Anemia	☐ Arthritis	☐ Psychiatric Treatment
☐ Stroke	☐ Rheumatism	☐ Sickle Cell Disease
☐ Kidney Trouble	☐ Cortisone Medication	☐ Bruise Easily
☐ Ulcers	☐ Glaucoma	☐ Bleeding Disorder
☐ Cancer or Tumor	☐ Venereal Disease	☐ **None of the above apply**

Women: Are you pregnant? Yes No If yes, what month are you due? _____

- Do you have any disease, condition or problem not listed? Yes No
- If yes, explain: _____

Please list all medications you are currently taking: _____

*** If you brought a medication list with you, please notify the front desk.**

Have you ever had a reaction to a local anesthetic? Yes No

I, the undersigned, affirm that the information above is accurate and complete to the best of my knowledge. I will not hold my endodontist or any member of the office staff responsible for errors or omissions that I made in the completion of this form. I consent to any advisable and necessary endodontic therapy to be administered by the endodontist or his staff for diagnostic purposes or dental treatment. I understand that root canal therapy is an attempt to save a tooth which otherwise would be lost. Although root canal therapy has a very high degree of clinical success, it is still a biological procedure, so it cannot be guaranteed. Occasionally a tooth which has had root canal treatment may require retreatment, surgical intervention or even extraction.

UPON COMPLETION OF ROOT CANAL TREATMENT, I AM TO RETURN TO MY GENERAL DENTIST FOR THE PERMANENT RESTORATION (FILLING OR CROWN).

Signature: _____ **Date**: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I authorize the release of my confidential protected dental information. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential dental information.

I have reviewed a copy of this office's **Notice of Privacy**. (Attached to clipboard)

Print Name: _____ **Date:** _____

Signature: _____

Treatment Consent

I understand Root Canal treatment is a procedure to retain a tooth which may otherwise require extraction. Although Root Canal therapy has a very high degree of success, it is still a biological procedure. Therefore, the procedure cannot be guaranteed. Occasionally, a tooth which has had Root Canal Therapy may require retreatment, surgery, or extraction.

Although rare, the following complications may occur in endodontic therapy: Pain and swelling, damage to an existing filling or crown, perforation of the root.

I understand that only the root canal treatment is to be performed at this office. The outside restoration (such as a crown) will be done by my regular dentist. In light of all this information, I hereby authorize either Dr. Reed, Dr. Perrins or Dr. Lemire to proceed with treatment on tooth #_____.

I have reviewed the above paragraph containing this office's **Root Canal Treatment Consent**.

Signature: _____ **Date:** _____