Harp Endodontics PC

Patient Information
Last Name: _____
First Name: _____
Sex: ☐ Male ☐ Female ☐ _____
Date of Birth: ____/____/____
Marital Status: ☐ Single ☐ Married ☐ Other
SSN: _____-_____-_____
Address: _____
City: _____ State: ____ Zip Code: _____
Email: _____
Home#: _____ Cell#: _____
Employer: _____
Occupation: _____

Referred By: _____

Medical History
Physician's Name: _____
Phone #: _____
Date of Last Medical Exam: _____/_____/_____
Is your general health good? ☐ YES ☐ NO
Has there been a change w/in the last year? ☐ YES ☐ NO
Were you ever hospitalized? ☐ YES ☐ NO
Have you had a serious illness? ☐ YES ☐ NO
Are you being treated by a physician now? ☐ YES ☐ NO
For what conditions? _____
Have you ever used bisphosphonates? ☐ YES ☐ NO
Are you taking aspirin? ☐ YES ☐ NO
Are you taking any blood thinners? ☐ YES ☐ NO

Emergency Contact:
Name/Relation: _____
Home#: _____ Cell#: _____

Dental Insurance Information:
Insurance Company: _____
Employer: _____
Subscriber's Full Name: _____
Date of Birth: _____/_____/_____
SSN: _____-_____-_____
Insurance ID#: _____
Plan/Group Number: _____

Dental History:
What is your primary dental concern? _____
_____
Are you in pain or discomfort? ☐ YES ☐ NO
If YES, please explain: _____
Last dental visit: _____/_____/_____
Last dental x-rays taken: _____/_____/_____
How often do you brush? _____ / day
How often do you floss? _____ /day
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?
Please select one: ☐ YES ☐ NO

For Women:
Are you or could you be pregnant/ nursing? ☐ YES ☐ NO
Taking birth control pills? ☐ YES ☐ NO

Medical History: Do you or have you had (Please check either YES or NO)

YES	NO		YES	NO		YES	NO	
☐	☐	Anemia or bleeding problems	☐	☐	Dizziness/Fainting	☐	☐	Lung disease
☐	☐	Anaphylaxis	☐	☐	Dry mouth	☐	☐	Pacemaker
☐	☐	Arthritis, rheumatism	☐	☐	Epilepsy or Seizures	☐	☐	Persistent cough
☐	☐	Artificial joint	☐	☐	Heart attack	☐	☐	Prosthetic heart valve
☐	☐	Asthma, TB, emphysema	☐	☐	Heart disease	☐	☐	Psychiatric care
☐	☐	Cancers/Tumors	☐	☐	Heart murmur	☐	☐	Rheumatic fever
☐	☐	Chemotherapy/Radiation	☐	☐	Hepatitis, other liver disease	☐	☐	Sinus problems
☐	☐	Chest pain (angina)	☐	☐	HIV/AIDS	☐	☐	Stomach ulcers
☐	☐	Cortisone treatments	☐	☐	High blood pressure	☐	☐	Stroke
☐	☐	Diabetes	☐	☐	Kidney, bladder disease	☐	☐	Thyroid or adrenal disease
☐	☐	Difficulty swallowing	☐	☐	Other: _____	☐	☐	Parkinson's

Are you using/taking?
Tobacco in any forms ☐ YES ☐ NO
Recreational Drugs ☐ YES ☐ NO
Alcohol ☐ YES ☐ NO
Do you have any known allergies to drugs, food, medications, latex? ☐ YES ☐ NO _____
Are you currently taking any medications? ☐ YES ☐ NO
If yes please list all: _____
Do you have or have you had any other medical conditions **NOT** listed on this form? _____
_____

Terms & Conditions

*** Endodontic (root canal) therapy is an attempt to save a tooth which would otherwise be removed because of pulpal disease. This is accomplished by using nonsurgical procedures, but on occasion surgery is necessary. *Alternative Choices to Root Canal Therapy*:** Other treatment choices include: no treatment, waiting for more definitive symptoms to develop, or tooth extraction. Risks involved in these choices might include pain, swelling, loss of teeth, and infection to other areas.

Consent for Treatment: I hereby authorize the dentist or designated staff from *Harp Endodontics PC* to take x-rays, CBCT scans, photographs and other diagnostic aids deemed appropriate by the dentist to make a thorough diagnosis as mutually agreed upon by me. Upon such diagnosis, I authorize the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide the appropriate care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. Included (but not limited to) are complications resulting from the use of dental instruments, drugs, analgesics (pain killers), anesthetics and injections. These complications include swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth which is transient but on infrequent occasions may be permanent; reaction to injections; changes in occlusion (bite); jaw muscle cramps and spasms; temporomandibular jaw (joint) difficulty; loosening of teeth; referred pain to the ear, neck and head; nausea, vomiting; allergic reactions; delayed healing' sinus perforations and treatment failures. I understand that I can ask for a complete recital of any possible complications.

Risks more specific to endodontic therapy: The risks include the possibility of instruments broken within the root canals; perforations (extra openings) of the crown or root of the tooth; damage to bridges, existing fillings, crowns or porcelains veneers; loss of tooth structure in gaining access to canals, and cracked teeth. During treatment, complications may be discovered which make treatment impossible, or which may require dental surgery. These complications may include: blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease) and splits or fractures of teeth.

Consent for Release of Medical Records: I authorize *Harp Endodontics PC* to release to government agencies, insurance carriers, referring dentists or others who are financially liable for dental and medical care, all information needed to substantiate payment for such care, and allow others who are representatives thereof to examine and make copies of all records relating to my care and treatment.

Estimated Insurance Coverage: As a courtesy, our practice will bill your insurance and help you receive the maximum allowable benefit under your policy. Please understand that the estimated insurance coverage provided is an estimate only, and not a guarantee of payment or benefits. Received benefits, which are contingent on the remaining benefits of the patient's plan at the time of your insurance carrier's processing, may not match *Harp Endodontics'* projected estimate. In this case, the patient is fully responsible for all charges that are not covered by insurance benefits. -I authorize the use of my insurance for payment submissions -I authorize direct payment to my doctor -I authorize my doctor to act as my agent in helping to obtain payment from my insurance company.

Payment for Treatment: I agree to be responsible for payment of all services rendered on my behalf and/or on behalf of my dependents. I understand that payment is due at any time of service unless other arrangements have been made. We expect and appreciate payment at the time of treatment. We accept Visa, MasterCard, American Express, personal check and cash. We also can process your private health fund claim at the time of your appointment but need your card at every visit.

-I authorize that I am responsible for all of my bills (copayments, coinsurances, deductibles, etc.) -By entering and submitting your credit card details, you consent to the secure storage of your payment information in compliance with relevant privacy and security standards. This information will be used solely for future transactions, including processing refunds if necessary, and will not be shared with third parties unless required by law or for processing payments

Cancellation Policy: We have a 48 hour (2 business days) cancellation policy to allow us ample time to offer your appointment to another patient in need of it. A fee of $50 will be charged for missed appointments or failure to reschedule before the 48 hour time limit. I understand the consent for treatment, the payment and cancellation policies as stated above. By my electronic signature below, I agree to the terms and conditions.

Permission to Communicate: Our practice may contact you via email and/or mobile number(voice/text message) to remind you of an appointment or balance, to collect a balance, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. -I authorize to receive voice and text messages for appointment and billing reminders, feedback, and general health reminders.

X _____ **Print Full Name:** _____ **Date:** _____