Southside Endodontics, P.C.

Patient Registration

Date _____

Name _____
Last Name First Name Initial Preferred Name

Address_____

City_____ State _____Zip_____

Home Phone _____Business Phone _____Cell Phone_____

Sex: □ M □ F Birth Date _____ Social Security#_____

Employer _____Occupation_____

Business Address_____

In case of emergency, who should be notified? _____

Relationship _____ Phone _____

Referring Doctor _____ Tooth # _____

Medical History

Have you had or do you have any of the following: (check boxes that apply)

□ heart failure
□ heart disease or attack
□ angina
□ high blood pressure
□ Osteoporosis
□ Osteopenia
□ congenital heart defects
□ prosthetic (artificial) heart valve
□ pacemaker/defibrillator
□ heart surgery
□ arrhythmia/dysrhythmia
□ stroke
□ other heart problem
□ hepatitis
□ HIV/ AIDS
□ chemical dependency
□ other medical condition not listed

□ asthma
□ emphysema
□ tuberculosis
□ other respiratory problem
□ ulcer/colitis
□ cancer
□ radiation tx/ chemotherapy
□ hemophilia/ prolonged bleeding
□ thyroid problems
□ diabetes
□ epilepsy/seizures
□ glaucoma
□ kidney disease
□ arthritis
□ artificial joint
□ psychiatric care

_____

Medications currently taking (including non-prescription medicines):

_____

Have you been advised to take a Premed before seeing a Dentist?
□ Yes □ No, If so, What _____
Are you allergic to any medications or drugs? □ Yes □ No If so, what _____
_____

Are you currently taking or have you previously taken bisphosphonate medications (medicine for your bones), such as Actonel, Boniva, Fosamax, or Zometa, within the past twelve years?
□ Yes □ No, If so, how long? _____

Are you allergic to latex? □ Yes □ No
Are you allergic to bleach? □ Yes □ No
Physician's name _____ Phone # _____
(For Women) Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No
Name of OB/Gyn Physician _____Phone_____

Condition of Acceptance - ALL PATIENTS PLEASE SIGN!!

I understand and agree that in accordance with Section 32.1-45.1 of the code of Virginia, that if a healthcare worker is exposed to my body fluids in a manner which may transmit HIV or Hepatitis B or C viruses, then I deem to have consented to testing for infection with HIV or Hepatitis B or C viruses, and to the release of such test results to the person exposed.

Signature:_____ Date: _____

Dental Insurance
Primary Dental Insurance

Insurance Co. Name _____ Tel.#_____
Group # _____ Employer of Insured _____
Insured's Name _____Relation_____
Birthdate of Insured _____ SS# or ID# _____

Secondary Dental Insurance

Insurance Co. Name _____ Tel.#_____
Group # _____ Employer of Insured _____
Insured's Name _____Relation_____
Birthdate of Insured _____ SS# or ID# _____

I give permission for Southside Endodontics to leave a message on this phone number _____ regarding my co-pay, appointments, billing, and patients account ect.

_____
Signature of Patient or legal designate Date

Endodontic Consent and Information Form

We want to inform our patients about the various procedures involved in endodontic therapy and have their consent before starting treatment. Endodontic (root canal) therapy is performed to save a tooth, which would otherwise need to be removed. The alternatives to endodontic therapy include: no treatment or extraction. Risks involved in these alternative choices might include pain, infection, swelling and tooth loss.

Endodontics or root canal therapy is cleaning, shaping, disinfecting and filling the space inside of the root of the tooth. A treated tooth usually functions normally and is a pulpless tooth, not a dead tooth. Treatment will require one or more visits depending on the condition of the tooth. Almost always a local anesthetic will be needed to anesthetize (numb) your tooth. A number of x-rays will be taken during the procedure. Please be advised of the following:

(1) 90% of routine cases are successful. Endodontics, as with any branch of medicine or dentistry, is not an exact science. Thus no guarantee of treatment success can be given or implied. If the original treatment is not successful, the tooth may need to be retreated, a surgical procedure may be required, or the tooth may need to be removed.

(2) Endodontic treatment started in other offices or re-treatment cases may have a different outcome than expected under optimal conditions.

(3) Proper post-treatment restoration of the treated tooth is a necessity. Please contact your dentist soon after the completion of treatment to have the tooth restored. It is your dentist's responsibility to restore the tooth. Most teeth will require a crown to prevent the tooth from breaking. Do not chew hard foods on the tooth until the crown is placed to protect the tooth from breaking or cracking. If the tooth splits, it may require extraction.

(4) Possible unavoidable complications of endodontic therapy include but are not limited to:
Swelling, soreness, or muscle spasm.
Fracture of the tooth or crown or bridge. If the tooth has a crown or bridge on it, we will have to drill through the crown, which may result in the crown having to be replaced. If the crown, bridge or existing restoration must be replaced, it is the patient's responsibility. It is not our responsibility to fabricate or pay to fabricate a new restoration for you.
Separation or breakage of a root canal instrument during treatment.
Perforation of the root.
Adverse reactions to anesthetics and medications administered and prescribed for treatment.

(5) Some canals are blocked and may make root canal treatment impossible. These blockages can be caused by calcified canals, severely curved roots, root resorption, posts, fillings or prior treatment.

(6) Patients who are taking bisphosphonates (medicine for the bones) have a small risk of developing osteonecrosis of the jaw from root canal therapy.

I hereby give my consent to the performance of endodontic treatment. I further give my consent for the administration of medications, anesthetics, and services deemed necessary to treat my endodontic problem, understanding the risks involved.

Signature of Patient or legal designate Date

Signature of Doctor Date

Payment Information

Each patient is financially responsible for his or her own account. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. As a courtesy, we will file all insurance claims for you.

Consultation, local anesthesia, emergency treatment fees, and incomplete root canal treatments are due in full at the time of service, regardless of the type of insurance you may or may not have.

Fees for root canal treatment are paid in the following manner:
( ) Patients without dental insurance. Payment is expected in full. Payment may be made by cash, check or credit card.
( ) Patients with dental insurance. As a courtesy, we will file all insurance claims. We will call your insurance company to get their **estimated** co-payment whenever possible. If we are not able to get an **estimated** co-payment from your insurance company, 35% of the root canal fee is to be paid at the beginning of treatment and all insurance benefits are payable directly to Southside Endodontics, PC. When all insurance benefits have been received, if any overpayment has been made, a refund will be promptly sent to you. If there is an additional amount due, we will send a statement for the balance, which will then be payable in full upon receipt. All unpaid balances are the patient's responsibility.

If root canal treatment is started, but it is found that the tooth is not salvageable or root canal treatment can not be completed, you will not be charged the full fee for the root canal treatment. Instead of the full fee, there would be a fee of $250.00 for services provided.

I understand that if payment is not made when the account is due, there will be a finance charge of 1 1/2% per month (18% APR) and the account may be turned over for collection. I will be responsible for any and all costs associated with the collection process, including but not limited to billing costs, collection fees, lawyers fees and court costs.
Accounts will be turned over to a collection agency if the balance is not paid in full within 60 days.
A $25.00 charge will be added to your account for all returned checks.

I have read and understand the above.

Signature _____ Date _____