Name _____ Work Phone _____
Address _____ Home Phone _____
City, State, Zip _____ Cell Phone _____ Employer (or Spouse's) _____
EMail: _____ Occupation _____
Sex _____ SS# _____ Referred By _____
DOB _____ Age _____ General DDS _____ _____
Nickname _____

Is this Dental Treatment covered by insurance?
☐ Yes ☐ No
If so, name of insurance company _____
Subscriber Full Name _____
Date of Birth _____
S.S. # or ID # _____

DENTAL INSURANCE

As a courtesy to our patients, we will be happy to complete an insurance form relative to endodontic treatment. Our professional services are rendered to you not the insurance company. You are directly responsible to us for the obligation of payment for treatment. You will then be reimbursed by your insurance company. Only in this manner can we achieve the best interpersonal relationship and optimum treatment demanded.
The financial obligation for dental treatment is between you and this office and is not dependent on insurance coverage.

CONFIDENTIAL MEDICAL-DENTAL HISTORY

Medical Physician's Name _____ Phone No. or Address _____
Date of last physical exam _____ Are you now or have you recently been under a physician's care? _____
Reason _____
Have you ever been a patient in a hospital or had any serious illness? Explain: _____
Check any of the following which you have **had** or **suspected:**

Yes	No		Yes	No		Yes	No	
☐	☐	Arthritis	☐	☐	Hepatitis or Jaundice	☐	☐	Prolonged Bleeding
☐	☐	Rheumatic Fever	☐	☐	Cancer or Tumor	☐	☐	Epilepsy
☐	☐	Heart Trouble	☐	☐	Tuberculosis	☐	☐	Thyroid Disease
☐	☐	Heart Murmur	☐	☐	Diabetes	☐	☐	Glaucoma
☐	☐	High or Low Blood Pressure	☐	☐	Kidney or Bladder Trouble	☐	☐	Radiation (X-Ray) Treatment
☐	☐	Chest Pain	☐	☐	Anemia	☐	☐	Fainting Tendency
☐	☐	Stroke	☐	☐	Lung Disease	☐	☐	Mental Disorders
☐	☐	Shortness of Breath	☐	☐	Venereal Disease	☐	☐	AIDS/HIV
☐	☐	Asthma or Hay Fever	☐	☐	Blood Disease	☐	☐	ARC (Aids Related Complex)
☐	☐	Sinus Trouble	☐	☐	Liver Disease	☐	☐	Other _____
☐	☐	Osteoporosis						

NOTES _____

Check any of the following drugs you are taking or have taken:
☐ Cortisone Drugs ☐ Anticoagulants ☐ Tranquilizers ☐ Bone Density Medicine
☐ Steroids or ACTH ☐ Blood Thinners ☐ Sedatives
Are you taking any other medicines? (list) _____
NOTES _____

Are you allergic to or suffer ill effects from (check if applicable)?
☐ Penicillin ☐ Codeine ☐ Latex ☐ Dental Anesthetics
☐ Aspirin ☐ Sedatives ☐ Hydrocodone ☐ Other _____
Are you allergic to any other medications or anesthetics? _____
Explain: _____
Women only: Are you pregnant? _____ How many months? _____
Are you breast feeding your child? _____ Do you have any problems associated with your menstrual period? _____
Are you presently taking any medicine of any kind routinely? (Birth Control Pills, Hormones, etc.) _____

CONSENT STATEMENT

I understand and authorize the performance of root canal treatment on _____ (myself or name of patient) if necessary, including the use of local anesthesia, sedation, and medications, and authorize additional procedures which the dentist may consider necessary or advisable in the course of the planned treatment. I understand that root canal treatment is an attempt to save a tooth that might otherwise be lost. I understand that any opening made in the tooth will be sealed with a temporary material and the permanent restoration (filling, crown, etc.) will be done by my regular dentist. I realize that the practice of dentistry is not an exact science and, therefore, reputable practitioners cannot guarantee results. No guarantee has been given by anyone as to the results that may be obtained. I realize that I am financially responsible for charges related to this treatment and full payment is due by the day of treatment completion. To the best of my knowledge, the above medical history information is true, I understand the treatment to be performed, and I consent as stated.

Date _____ _____
Signature of patient (parent or guardian for a minor)

Endodontic Associates, PLLC

Endodontic Consent and Information Form

We would like our patients to be informed about the various procedures involved in endodontic therapy and have their consent before starting treatment. Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by conservative root canal therapy, or when needed, endodontic surgery. The following discusses possible risks that may occur from endodontic treatment and other treatment choices.

RISKS: The risks include the possibility of instruments broken with the root canals, perforations (extra openings) of the crown or root of the tooth, damage to bridges, existing fillings, crowns or porcelain veneers, and 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), or splits or fractures of the teeth.

MEDICATIONS: Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives, or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effects. Any antibiotics (penicillin, keflex, erythromycin, etc.) that may be prescribed can reduce the effectiveness of oral birth control medications. Please ask me and /or your pharmacist if you have any questions. If you are taking medications check with your pharmacist about interactions.

OTHER TREATMENT CHOICES: These include no treatment (waiting for more definite development of symptoms) or tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infection to other areas.

CONSENT: I, the undersigned, being the patient (parent or guardian of minor patient) consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. I also understand that upon completion of root canal therapy in this office I shall return to my general family dentist for a permanent restoration of the tooth involved such as a crown, cap, jacket, onlay or silver filling.

I understand that root canal treatment is an attempt to save a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery or even extraction.

Signature Date

Statement of Patient Rights Receipt

I acknowledge that I was provided with Endodontic Associates PLLCs' statement of patient rights.

Print the Name of the Patient: _____

Signature of the Patient: _____

Patient's Date of Birth: _____

Notice of Privacy Practices Receipt

I acknowledge that I was provided with the Notice of Privacy Practices of Endodontic Associates PLLC.

Signature of Patient: _____

Permission for Verbal Communication

I permit Endodontic Associates PLLC, their physicians, dental assistants, and other office personnel to discuss health information in person or by telephone, with the following family members or friends involved in my dental care: (List family members/friends and state the person's relationship to the patient).

This authorization is limited to discussion regarding the following dental condition(s):_____
(If no limitations are listed, discussions will be permitted regarding any dental condition for which the patient has received care).

Name	Phone Number	Relationship
1._____	_____	_____
2._____	_____	_____

Release of information under this document is limited to verbal discussions with My Health Care Providers. This document does not permit release of any written health information to the individuals named above.

This authorization is limited to the following timeframe from _____ (date) to _____(date). If no dates are indicated, this form will remain in effect for an unlimited amount of time.

If, at any time, I do not want verbal discussions to be permitted between Endodontic Associates, PLLC and any of the individuals named above, I must notify Endodontic Associates PLLC by contacting the office manager.

You may refuse to sign this acknowledgement
If you refuse to sign please ask for alternate form.

Patient's Signature: _____ Date: _____

Good Faith Estimate

If you do not have health insurance or plan to pay for dental services and procedures yourself, under the law, you have the right to receive an estimate of your bill for healthcare items and services prior to those items being provided. This is called a Good Faith Estimate.

A good faith estimate shows the total expected cost of any health care items or services. The estimate is based on information known to the provider at the time the estimate is created. The good faith estimate does not include any unknown or unexpected costs that may be added during your treatment.

This estimate is not a contract and does not require you to obtain the services at this office. The good faith estimate may not include additional items that may be recommended for post treatment care or rehab services.

Providers and facilities must give you the good faith estimate if you schedule an item or service at least 3 business days before the date you are scheduled to receive the item or service. Secondly, the provider must give you a good faith estimate no later than 1 business day after scheduling.

If you schedule the item or service or ask for cost information about it at least 10 business days before the date you get the item or service, the provider or facility must give you a good faith estimate no later than 3 business days after you schedule or ask for the estimate. The GFE should include a list of each item or service and the health or dental service code along with the total estimated cost.

The good faith estimate must be provided in an accessible format in compliance with nondiscrimination laws. Providers and facilities must also explain the good faith estimate to you over the phone or in person if you ask, then follow up with a written (paper or electronic) estimate, per your preferred form of communication.

If you receive a bill for an amount that is at least $400 more than your Good Faith Estimate from that provider or facility, you can dispute the bill.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

PATIENT FINANCIAL AGREEMENT & RELEASE OF INFORMATION

The following is a statement of the Practice's financial policies, which you must read and agree to prior to any treatment.

1. PAYMENT. Payment of any unmet deductible, co-insurance, co-payment, and any charges not covered by insurance is expected at the time of your visit. We accept cash and major credit cards. In addition, we may have additional financing options available to you on or after your initial date of service.

2. INSURANCE, DEDUCTIBLES, CO-PAYMENTS, AND CO-INSURANCE

- It is your responsibility to confirm which treatments or procedures are covered and/or paid by insurance (including, but not limited to, any applicable exclusions, deductibles, and annual or lifetime maximums) & any referrals required by your insurance.
- As a courtesy, we will file your insurance claim for you; however, please remember that insurance is NOT a guarantee of payment. In order to bill your insurance and to meet filing guidelines, we require a copy of your insurance card and a photo ID.
- We can only approximate the percentage covered by each plan. Payment of the ESTIMATED portion as well as your co-payment is due at time of service.
- Any estimate of insurance coverage may differ from what your insurance carrier ultimately pays. You will be responsible for any charge that insurance determines to be not covered.
- **NOTE: If your doctor has recommended General Anesthesia, this does NOT mean your insurance will consider this to be a "Medically Necessary" procedure and pay for this service
- As the parent or guardian accompanying a minor, you are financially responsible for all charges, whether or not paid by insurance.
- In situations of divorce, separation, court orders, etc., the adult who signs in a minor child on the day of treatment accepts financial responsibility for payment.
- Non-covered procedures will not be filed to insurance.
- Private pay/uninsured patients: (i) you must pay in full at time of service, and (ii) you hereby acknowledge receipt of a Good Faith Estimate as required by 45 C.F.R. §149.610 by signing below.

3. BILLING AND COLLECTION.

- Payment is due as stated on any billing statement mailed, emailed or otherwise delivered to you. If we do not receive payment within fifteen (15) days of the due date, your account shall be past-due.
- Interest at the maximum rate amount allowed by law will be charged on all past due accounts.
- Past due accounts may be placed with a collection agency or attorney for collection.
- In addition to the charges for services and treatment received, you agree to be responsible for and to pay all costs and expenses incurred in the collection of amounts past due on your account including, but not limited to, collection agency fees (either 33.33% of the amount due or the maximum amount allowed by applicable law), reasonable attorney's fees and expenses, collection expenses, and court costs. If your account is turned over to collections, you hereby accept any such fees and costs as a legal and lawful debt and agree to paid said fees, including any and all resulting fees and costs. You hereby waive your right of exemption under any applicable laws.
- If your account is turned over for collections, you will no longer be able to receive services from the Practice until your delinquency is cured.

4. CONSENT TO CONTACT. The Practice and anyone contacting you on our behalf may contact you for any purpose and in any manner permitted by law. You also expressly consent to be contacted by the Practice, and anyone contacting you on our behalf, for any purpose, including billing, collection, or other account or service-related purpose, at any telephone number or physical or electronic address where you may be reached, including any wireless telephone number. We and/or anyone contacting you on our behalf may contact you in any way, such as calling, texting, emailing, sending mobile application push notifications, or using any other method of communication permitted by law. You agree that the Practice, and anyone contacting you on our behalf, may communicate with you in any manner, including through the use of an artificial or pre-recorded voice message or an automatic telephone dialing system. We may contact you on a mobile, wireless, or similar device, even if you are charged for it.

I have read the financial policies above, and my signature below indicates my agreement to these policies and acceptance of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for any services provided to me, I assume financial responsibility and will pay all such charges in full.

I hereby authorize the Practice to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the Practice all insurance benefits otherwise payable to me for the Practice's services.

_____	____/____/____
Patient Name	Patient DOB
_____	_____
Patient or Responsible Party Signature	Date
_____	_____
Printed Name of Responsible Party (if applicable)	Relationship to Patient (if applicable)

(Version 11.2023)