Patient Information

Dr.◯Mr.◯Ms.◯Mrs.◯Miss◯ **(Please circle one)**

Last _____ First _____ Middle _____

Preferred Name _____

Date of Birth _____ Social Security # _____

Mailing Address _____ City _____ State _____

Zip _____

Home # (____) _____ Cell# (____) _____ e-mail _____

Preferred method of appointment confirmation; circle one: Home Phone Cell Phone

Employer _____ Phone (____) _____

Referring Dentist _____ General Dentist _____

How long have you been a patient in their office? _____

Spouse/Guardian (Please circle one, or note relationship to patient)

Last Name _____ First _____ Middle _____ D.O.B. _____

Address _____ City _____ ST _____ Zip _____

Home # (____) _____ Cell # (____) _____

Emergency Contact (if different) _____ ***Phone*** (____) _____

Relationship to patient: _____

Employer _____ Phone _____

Dental Insurance Information (must be filled out) - Please Advise Us If You Have Dual Insurance Coverage

Dental Ins. Plan _____ Policy Holders Name _____

Policy Holders SS#/ID # _____ Date of Birth _____

Relationship to Patient _____ Employer _____

Group Policy # _____

Patient Acknowledgement

I understand that I have certain rights regarding my protection of health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) I understand that by signing this consent I authorize you to use and disclose my health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of our practice.

I have been given a copy of your *Notice of Privacy Practices* to review. I understand that you reserve the right to change the terms of this notice and I may contact you at any time to obtain the most current copy.

I understand that I have the right to request restrictions, in writing, on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date that I revoke this consent is not affected.

Please use the space provided to list the people to whom you give written authorization for us to disclose your health information to;

Spouse/Significant other: _____

Family Member _____ Relationship _____

Other _____Relationship_____

May we leave health information on your answering machine service? Yes ◯ No ◯

Signed this ____ Day of _____, 20___

Print Patient Name: _____

Relationship to Patient _____

Signature _____

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
- ○ Other (Please specify)

_____

Health History

Patient Name: _____

D.O.B: _____

Please check all that apply (current or past)

1. ☐ heart condition or heart surgery
2. ☐ high blood pressure
3. ☐ regular use of aspirin or arthritis medication
4. ☐ endocarditis
5. ☐ liver disease
6. ☐ Hepatitis A☐ B☐ C☐
7. ☐ bleeding disorder
8. ☐ anemia
9. ☐ bisphosphonate use (bone density medications such as Fosamax, Actonel, Boniva)
10. ☐ history of TMJ disorder
11. ☐ history of clenching or grinding teeth
12. ☐ GI disorders
13. ☐ ulcers
14. ☐ Diabetes Type:_____Recent A1C measurement:_____ Glucose:_____
15. ☐ kidney disease
16. ☐ tuberculosis
17. ☐ asthma
18. ☐ COPD if yes, on oxygen_____liters per minute
19. ☐ thyroid/hormonal condition
20. ☐ seizures
21. ☐ neurological condition
22. ☐ cancer or malignancy
23. ☐ psychiatric condition
24. ☐ HIV positive if yes, latest CD4 count_____
25. ☐ immune-compromising disease
26. ☐ joint replacement
27. ☐ premedication for dental appointments
28. ☐ chronic sinus condition
29. ☐ currently pregnant if yes, month:_____
30. ☐ active smoker

Please provide brief details for any items checked above

Item #

Please provide a list of all current prescription, over-the-counter, vitamin and supplemental medications:

Drug:	Condition being treated:

Allergy or intolerance to medications or materials (i.e. latex, penicillin, etc):

Drug/Material:	Reaction:

Medical doctor(s) name(s) and specialty:

Please provide further details for any other medical condition not previously noted:

To the best of my knowledge, all the preceding answers and information are correct and complete. I will update my records at my next appointment if any changes occur. I have reviewed and verified all information.

_____ _____

Patient Signature **Date**

_____ _____

Doctors Signature **Date**

Patient Information and Consent

What is root canal therapy and what are its benefits?

Root canal treatment is the procedure of cleaning diseased or infected tissues from the inside of the tooth followed by placement of a hermetic seal in the resulting root canal space. Using a local anesthetic, there is little or no discomfort to the procedure. When swelling is present, root canal treatment may also involve incisions of the gum, drainage of pus and the use of antibiotic therapy.

The main benefit of treatment is saving a tooth that which would otherwise require extraction, allowing it to contribute in a sound, healthy and functional dentition for many years, if not a lifetime.

The practice of endodontics also includes procedures such as tooth bleaching, inducing closure of immature diseased roots, treatment of traumatic injuries, root end surgery and the fabrication of posts and build ups under crowns.

What are the complications of treatment?

With a success rate of more than 95%, endodontic therapy is a very reliable dental procedure. Dr. James Wolcott is highly trained and uses only approved materials with the latest techniques. However, because endodontic therapy is a biological procedure, there can be no absolute guarantee regarding treatment success. Some very infrequent complications and risks include the possibilities of a split or fractured tooth, a damaged crown or bridge, separation of an instrument portion within the tooth which cannot be removed, and varying pain, swelling or infection. While rare, numbness of the lip, tongue, chin, cheek or teeth can occur and may not be reversible. The use of prescription medications during treatment may also result in unexpected drug reactions. Any of these complications could result in failure of the procedure requiring possible retreatment, surgery and/or extraction. While we want to advise you of possible issues, many teeth are saved every day with no complications or side effects.

What alternatives do I have?

Extraction of the tooth is the alternative. If the tooth is removed and not replaced, the empty space can create problems in tooth alignment because of shifting. This often results in periodontal (gum) disease and eventually loss of other teeth. The missing tooth on the other hand, may be replaced by a bridge, implant, or partial denture. The cost is typically more expensive than root canal treatment and may involve otherwise avoidable dental work on adjacent healthy teeth. Since bridges and partial dentures are also harder to keep clean, gum disease may result without meticulous home care. The option of no treatment results in the persistence or recurrence of pain, infection and eventual tooth loss. You are encouraged to seek a second opinion if you have any questions.

What are my responsibilities?

It is very important to provide your endodontist with a complete, accurate, medical history and health status on your health questionnaire, including any prior allergic or unusual reaction to food, drugs, anesthetics, or previous dental treatments. We also need to know if you are taking any other medications or over-the-counter medications, including birth control pills, aspirin or ibuprofen (Advil, nuprin etc.). **Since only root canal treatment is performed at this office, it is your responsibility to make an appointment with your regular dentist for a permanent restoration (filling, crown etc.).** Since the time of your appointment is reserved exclusively for you, it is important that you give us 24 hour notice if you must reschedule so that time may be given to someone else. It is also your responsibility to pay for services when they are rendered whether dental insurance coverage is in effect or not.

By my signature below, I acknowledge that I have read this consent form in its entirety and have been given the opportunity to ask questions. I hereby authorize Endodontics of New Mexico to perform appropriate examinations, diagnostic procedures, and indicated treatment. I also acknowledge financial responsibility for these services and agree to pay for them in full by completion of treatment. I understand that if my account becomes delinquent, it may be forwarded to an outside collections agency. If this happens, I will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees and collection agency costs.

_____

Print Patient Name

_____ **Date** _____

Patient's Signature or Patient Guardian Signature

(If patient is younger than 18, parent consent is required)

STATEMENT OF PRIVACY PRACTICES

We are dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability act. This includes issues relating to your treatment, and our dental care operations. You may give written authorization for us to disclose your information to anyone you choose, for any purpose; but it will never otherwise be given to anyone – even family members – without your written consent.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to current and former patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations and comply with the law. This may include your name, address, telephone number(s), social security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain third parties if it is deemed necessary. Regardless of the source, the information will always be protected to the full extent of the law.

Disclosure of Your Protected Health Information

As stated above, we may disclose information as required by law. This includes issues in which we reasonably believe you may be a victim of abuse, neglect, domestic violence or other crimes. We are also obligated to provide information to law enforcement officials under certain circumstances. We will not use your information for marketing purposes.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines and postcards.

Patient Rights

You have a right to get copies of your healthcare information; to obtain copies in a variety of formats; and to a list of instances in which our business associates, or we have disclosed your protected information, we may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can, also, notify the U.S. Department of Human Services.

We thank you for being a patient at our practice. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

_____ **DATE:**_____

Patient's Signature or Patient Guardian Signature

(If patient is younger than 18, parent consent is required)