EASTERN IOWA
ENDODONTICS

REGISTRATION FORM
(PLEASE PRINT)

PATIENT INFORMATION

Date_____ Referring Dentist _____

Patient Name (Mr. / Mrs. / Ms. / Dr.) _____

Address _____

City _____ State _____ Zip_____

Home Phone _____ Cell Phone _____

Social Security # _____ Date of Birth _____

Email address _____

Employer _____ Business Phone _____

Emergency Contact _____ Phone _____

Has any member of your family been treated at our office? Yes ☐ No ☐ Who _____

PRIMARY DENTAL INSURANCE INFORMATION

Employee _____ Choose One Self Date of Birth _____

Social Security # or ID # _____ Group # _____

Employer _____ Employer Phone _____

Employer Address _____

Insurance Company _____

Insurance Company Address _____

City _____ State _____ Zip _____

SECONDARY DENTAL INSURANCE INFORMATION

Employee _____ Choose One Self Date of Birth _____

Social Security # or ID # _____ Group # _____

Employer _____ Employer Phone _____

Employer Address _____

Insurance Company _____

Insurance Company Address _____

City _____ State _____ Zip _____

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HEALTH HISTORY

PATIENT NAME _____ BIRTH DATE_____

Are you under a physician's care now? YES ☐ NO ☐ If yes, please explain: _____

Physician's Name/Address _____

Do you require **PREMEDICATION** prior to dental treatment? YES ☐ NO ☐
If yes, for which of the following? Heart (Infective Endocarditis, Artificial Valve, etc.) ☐ Joint Replacement (Knee, Hip or other) ☐

Do you use **CONTROLLED SUBSTANCES**? YES ☐ NO ☐

Do you have a **LATEX ALLERGY**? YES ☐ NO ☐

Are you **ALLERGIC** to any of the following? NONE ☐

Codeine ☐ Local Anesthetics ☐ Penicillin ☐ Sulfa ☐ Other:_____

Have you taken or are you currently taking **BISPHOSPHONATE MEDICATIONS** (Ex. Actonel, Boniva, Fosamax, Zometa, etc.)? YES ☐ NO ☐

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Fainting/Dizziness
- ☐ Frequent Headaches
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis A, B or C
- ☐ High Blood Pressure
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Intestinal Disease
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Neuralgia/Neuritis
- ☐ Pacemaker
- ☐ Pain in Jaw
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Renal Dialysis
- ☐ Shingles
- ☐ Sinus Trouble
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Trigeminal Neuralgia
- ☐ Tuberculosis [active]
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease

Are you currently pregnant: YES ☐ NO ☐ Are you breastfeeding: YES ☐ NO ☐

Have you ever had any serious illness not listed above? YES ☐ NO ☐

If yes, please explain: _____

_____

PLEASE LIST ALL MEDICATION THAT YOU ARE CURRENTLY TAKING

1)_____ 4)_____ 7)_____

2)_____ 5)_____ 8)_____

3)_____ 6)_____ 9) _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

EASTERN IOWA ENDODONTICS

FINANCIAL POLICY & HIPAA

To avoid possible misunderstandings regarding payments for services rendered, we are providing you with this statement of our financial policy. If you have any questions or concerns about our payment policies, please do not hesitate to ask our office staff.

1) For your convenience, our office accepts cash, personal checks and all major credit cards for services.

2) In the event that you do not have dental insurance, we ask that payment be made in full at the time services are rendered.

3) Most dental insurance plans do not cover 100% of the cost of your treatment. Because of this, you will be asked to pay your co-insurance / co-payments and any deductible the day services are rendered.

4) We will estimate as closely as possible your coverage, but until we actually receive payment from your carrier, it is just that – an estimate. If we do not receive payment from your carrier within 60 days, the entire balance is due from you.

5) Please understand that we file and accept assignment of your insurance benefits as a courtesy to you. If your insurance denies coverage or does not pay *for any reason*, you are ultimately responsible for any and all charges incurred in our office.

6) Balances older than 90 days will be subject to collection proceedings. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees.

7) Returned checks will be subject to additional collection fees assessed by the bank.

Thank you for trusting our office with your dental care.

ACKNOWLEDGEMENT OF NOTICE OF FINANCIAL POLICY

My signature certifies that I have read and understand the above financial policy. I agree to abide by it, and will pay today for services rendered.

Signature (patient / guardian) _____ Date _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

My signature certifies that I have reviewed a copy of this office's Notice of Privacy Practices.

Signature (patient / guardian) _____ Date _____

EASTERN IOWA ENDODONTICS

INFORMED CONSENT FOR ENDODONTIC TREATMENT

1) I understand that the goal of root canal treatment is to save a tooth that might otherwise require extraction. Although root canal treatment has a very high degree of clinical success, it is a biological procedure and success cannot be guaranteed.

2) I have been informed of possible treatment alternatives including; extraction and no treatment at all.

3) I understand that there are certain inherent risks in any treatment plan or procedure. I understand that the following may be inherent or potential risks for the treatment I will receive.
    a) Swelling; sensitivity; bleeding; pain; infection;
    b) Numbness and/or tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth which is transient but on infrequent occasions may be permanent;
    c) Reactions to injections;
    d) Changes in occlusion (biting), jaw muscle cramps and spasm; tempromandibular joint difficulty
    e) Loosening of teeth, crown or bridges; or damage to existing restorations which may necessitate replacement of the restoration;
    f) Referred pain to ear, neck and head; delayed healing; sinus perforation;
    g) Treatment failure; complications resulting from the use of dental instruments (broken instrument, perforation of tooth, root or sinus), medications, anesthetics and injections, discoloration of the face;
    h) Reactions to medications causing drowsiness and lack of coordination; and antibiotics may inhibit the effects of birth control pills
    i) Further treatment may be necessary

4) I understand that this procedure will not prevent future tooth decay, tooth fracture or gum disease and occasionally a tooth that has had root canal treatment may require retreatment, endodontic surgery or extraction

5) I understand that once root canal treatment is completed, I must promptly return to my referring dentist to have the tooth restored. If I fail to have the tooth properly restored, I risk a failure of the root canal treatment, decay, infection, and tooth fracture and loss of the tooth.

6) I have been given the opportunity to discuss this form and question the doctor concerning the nature of treatment, the inherent risks of the treatment and the alternatives to this treatment

7) This consent form does not encompass the entire discussion I had with the doctor regarding the proposed treatment

_____ _____

Patient and/or Guardian Signature Date

_____ _____

Printed Name Tooth #