GHAZAL
endodontics
@ Laurel Manor

ACKNOWLEGEMENT OF PRIVACY PRACTICE

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1950 Laurel Manor Drive
Building 184
The Villages, FL 32162
Phone 352-753-0150 Fax 352-750-8072

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations, such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of this *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

Date: _____

Print Patient Name: _____

Signature: _____

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Patient Information

Name_____

Address_____

City_____ State_____ Zip Code_____

Birth Date_____ Social Security #_____

Phone: Home (____)_____ May we text or email you? Yes ◯ No ◯

Mobile (____)_____ Sex: **M** / **F** Marital Status_____

Email: _____ Pharmacy to send prescriptions : _____

Emergency Name/Relationship_____ Phone:_____

DENTAL Insurance

Subscriber Name_____ Social Security #_____DOB_____

Employer_____ Insurance Co._____

Insurance Co. Phone#_____ Group #_____

Relation to patient_____ ID#_____

Assignment & Release

Insurance: We accept most insurance companies. We will file your insurance as a courtesy. Your portion of the fees are estimates only. You are responsible for the fees that insurance might deny. The relationship with the insurance carriers is between subscriber and insurance company, not provider and insurance company.

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible any estimated copay at time of service. I am responsible for any balances due from any non-covered services or difference of what was estimated. I also authorize the dentist to release any information required for this claim. I authorize that my records can be used by the doctor if he so determines.

I certify that I have read or had read to me the contents of this form.

Signature_____

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Please Check YES or NO for the following questions

YES ◯ **NO** ◯ Are you sensitive or allergic to Local Anesthetics, Penicillin, Sulfa, Codeine, LATEX (ex: latex gloves)? **(Please circle which ones.)** List any other allergies _____

YES ◯ **NO** ◯ Are you taking blood thinning medication (Aspirin, Coumadin (INR___, Date_____, Plavix, Pradaxa, Eliquis, Xarelto, or _____)

YES ◯ **NO** ◯ Do you have joint prosthesis (Hip or Knee replacement)? If Yes, when were they placed? _____

YES ◯ **NO** ◯ Are you required to take (Pre-Med) antibiotics Prior to ALL dental treatment for heart condition or joint replacement?

YES ◯ **NO** ◯ Do you have High Blood Pressure? If YES, Is it Under Control? **YES** ◯ **NO** ◯

YES ◯ **NO** ◯ Do you have Diabetes? If YES, Is it Under Control? **YES** ◯ **NO** ◯ **A1C**_____

YES ◯ **NO** ◯ Are you taking or have you ever taken Bisphosphonates. (Medications for Osteoporosis or Chemotherapy.) (ex: Fosamax, Boniva, Zometa, Actonel, Aredia, Nerixia….?) How long?_____

- **Have you ever had or have any of the following?** (**Please circle**)

STROKE, BYPASS, HEART ATTACK, ANGINA, PACE MAKER, PROSTHETIC HEART VALVE, RHEUMATIC FEVER, ASTHMA, TUBERCULOSIS, HEPATITIS, JAUNDICE, KIDNEY TROUBLE, EPILEPSY, NERVOUS DISORDERS, MITRAL VALVE PROLAPSE, HIV POSITIVE or A.I.D.S., DRUG or ALCOHOL ABUSE, CANCER_____, RADIATION or CHEMOTHERAPY, SINUS PROBLEMS.

- **List any medications you are taking now?** (or attach a copy)

_____
_____
_____
_____
_____

- Other Medical issues not listed above? _____
- FEMALE PATIENTS ONLY: Are you pregnant? **YES** ◯ **NO** ◯ How many weeks?_____

PLEASE READ AND SIGN THE FOLLOWING SECTION

Treatment Authorization: I authorize and give consent to perform dental services, including X-rays, agreed between doctor and patient and/or parent or guardian to be necessary advisable including the use of local anesthesia and other medication as indicated. The information of my medical history is correct to the best of my knowledge.

Print Name _____ **DATE** _____

Signature_____

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Endodontic Consent and Information Sheet

Risks: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation medicines, analgesic (pain killers) anesthetics, and injections. These complication 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 (biting); jaw muscle cramps and spasms; temporomandibular jaw joint difficulty; loosening of teeth; referred pain to ear, neck, or head; nausea; vomiting; allergic reactions; delayed healing; sinus perforations if root canal surgery is performed and treatment failure.

Risks more specific to Endodontic therapy: The risks include the possibility of instruments separation within the root canals; perforations (extra openings) of the root; damage to bridges, existing fillings, crowns or porcelain 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), cracks 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.

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 (or 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 dentist for a permanent restoration of the tooth involved, such as a crown, onlay or 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.

I certify that I have read or had read to me the contents of this form.

Date:_____

Print Name:_____ **Signature:**_____

Patient (or Legal Guardian) **Patient** (or Legal Guardian)

Print Name:_____ **Signature:**_____

Witnessed by Witnessed by