



ALEX GHAZAL DMD PA
EXCELLENCE IN ENDODONTICS

ACKNOWLEDGEMENT OF PRIVACY PRACTICE

Alex Ghazal DMD, PA
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: _____





ALEX GHAZAL DMD PA
EXCELLENCE IN ENDODONTICS

Thank you for visiting Excellence in Endodontics. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name _____

Address _____

City _____ State _____ Zip Code _____

Employer _____ Birth Date _____

Driver's License # _____ Social Security # _____

Phone: Home (____) _____ May we contact you at work? Yes No

Work (____) _____ Sex: __ / __ Marital Status _____

Mobile (____) _____

Emergency Name/Relationship _____ Phone: _____

Insurance

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone# _____ Group # _____

Relation to patient _____ ID# _____

Assignment & Release

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due. 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 consent to the taking of photographs and X-Rays before, during and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

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

Signature _____ Date _____



Medical History and Information

Referred By: _____ General Dentist _____

Medical Care Provider: _____ Phone # _____

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 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 _____

Endodontic Consent and Information Sheet

Endodontics, or root canal therapy, is a specialty of dentistry devoted to the saving of teeth in which the pulp or nerves are affected. It is true that it is easier to extract a tooth than to save it, but the value of a natural tooth is irreplaceable. In addition, extraction and replacement is usually more costly.

We would like our patients to be informed about the various procedures involved in the 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 conventional root canal therapy, or, when needed, Endodontic surgery. The following discusses possible risks that might occur from Endodontic treatment, and other treatment choices including Endodontic surgery.

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 complications 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 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.

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.

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: _____
Patient (or Legal Guardian)

Signature: _____
Patient (or Legal Guardian)

Print Name: _____
Witnessed by

Signature: _____
Witnessed by