ELEVATION
ENDODONTICS

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date _____ Patient's Name _____
Last First Middle

Responsible Person (if patient is a minor) _____
Last First Middle

Address_____ City_____ State_____ Zip_____

Home Ph# (___)_____ Work Ph# (___)_____ Cell Ph# (___)_____

Soc. Sec. #_____ Email_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐Single ☐Married ☐ Widowed ☐ Divorced

Patient Employed by_____ Occupation _____

Business Address_____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone (___) _____

DENTAL INSURANCE

Primary: ☐ Policy Holder: _____

Relation to Patient _____ Birthdate _____ SS#/ ID#_____

Address (If different from patient's) _____ Phone (___) _____

City_____ State_____ Zip_____

Person Responsible Employed By_____ Occupation _____

Insurance Company_____Group#_____Phone (___)_____

Is the patient covered by additional dental insurance? ☐ Yes ☐ No

Secondary: ☐ Policy Holder: _____

Relation to Patient _____ Birthdate _____ SS#/ ID #_____

Address (If different from patient's) _____ Phone (___) _____

City_____ State_____ Zip_____

Person Responsible Employed By_____ Occupation _____

Insurance Company_____Group#_____Phone (___)_____

HIPAA

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law.
We use and disclose health information about you for treatment, payment, and healthcare operations. For example, we may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may use and disclose your health information to obtain payment for services we provide to you.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or disclose it to anyone for any purpose. If you give us an authorization, you may revoke in writing at any time. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To your family and friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, only if you agree that we may do so.

Persons involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

Marketing Health-related services: We will not use your health information for marketing communications without your written authorization.

Required by law: We may use or disclose your health information when we are required to do so by law.

Print name:_____ **Signature:**_____ **Date:**_____

AUTHORIZATION AND FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have Dental insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.
Payment for services is due at the time services are rendered. We accept cash, checks, and most credit cards. We want to emphasize that our relationship is with you, not your insurance company. We will be happy to help you process your insurance claim for your reimbursement. All charges are your responsibility from the date the services are rendered. Returned checks and balances older than 30 days may be subject to a finance charge of 18% per month.

By signing:

- I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered.
- I authorize the use of this signature on all insurance submissions. If there is any change in my medical status, I will inform the dentist.
- I authorize the dentist to release all information necessary to secure the payment of benefits.

*INSURANCES WITH HMO, DHMO, OR MEDICAID ARE NOT ACCEPTED.

Patient (Guardian) Signature_____ **Date:**_____

PATIENT ROOT CANAL CONSENT

I understand Root Canal treatment is a procedure to retain a tooth which may otherwise require extraction. Although Root Canal Therapy has a very high degree of success, it is still a biological procedure. Therefore, the procedure cannot be guaranteed. Occasionally, a tooth which has had Root Canal Therapy may require retreatment, surgery, or extraction.

In order to increase the chance of achieving optimal results, I have provided an accurate and complete medical history, including all past and present dental and medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable). Your doctor will be happy to answer any questions you may have and provide additional information before you decide whether to proceed with the procedure.

1. I have been informed of and understand the potential risks related to this procedure include but are not limited to:

- Post-treatment discomfort, incomplete treatment due to blocked root canals, recurrent infection, gum irritation, damage to adjacent teeth, fracture of existing crown, temporary or permanent numbness, instrument separation in the canal, perforations of the tooth root, cracking and/or stretching of the corners of the mouth, stress to the jaw joints (TMJ), altered bite, change in aesthetic appearance of teeth, allergic and/or adverse reaction to medications and/or materials.

- This procedure will not prevent future tooth decay, tooth fracture or gum disease, and occasionally a tooth that has had Root Canal Therapy may require re-treatment, endodontic surgery, or tooth extraction.

2. I understand the risks associated with anesthesia including but not limited to:

- Allergic or adverse reactions to medications or materials, pain at the anesthesia injection site, bruising/swelling, nerve injury, nausea, vomiting, disorientation, confusion, lack of coordination, drowsiness, heart and breathing complications, numbness following anesthesia that in rare instances may be permanent, overdose.

3. I understand that follow up visits or care, additional evaluation and/or treatment may be needed.

- I agree to follow all instructions provided to me by this office before and after the procedure, take medication(s) as prescribed, practice proper oral hygiene, keep all appointments, make return appointments if complications arise, and complete care. I will inform my doctor of any post-operative problems as they arise.
  My failure to comply could result in complications with less than optimal results.

- I understand and accept that the doctor cannot guarantee the results of the procedure. I had sufficient time to read this document, understand the above statements. By signing this document, I acknowledge and accept the possible risks and complications of the
  procedure and agree to proceed.

Patient (Guardian) Signature_____ **Date:**_____