ESTIMATE AGREEMENT

ANY estimate you pay at our office is ONLY an estimate. This estimate is based on information that your insurance company has provided to us either by telephone, fax, or their website.

Our verbal and/or electronic verification of benefits is NOT a guarantee of payment and you are responsible for any amounts you insurance fails to cover. You could receive a bill or a refund after the insurance company processes the claim and pays us according to your dental plan agreement.

Please feel free to ask any questions you may have regarding this prior to treatment. We want all our patients to have a full understanding of what an estimate is.

Thank you!

Sign and date_____

Patient Profile

Name: _____

Address: _____

City: _____ ST: _____ Zip: _____

Sex: Male Female

Home: _____ Cell: _____ Work: _____

DOB: _____ SS#: _____ email: _____

Employer: _____ Address _____

Employer Contact Phone Number _____

General D.D.S: _____ Referred By: _____

Preferred Pharmacy: _____ phone #: _____

Emergency Contact: _____ phone #: _____

Your ALLERGIES **Please circle if applies to you:**

No Allergies
Antibiotics _____
Artificial Sweeteners
Aspirin
Bleach
Codeine
Food _____
Iodine/Seafood
Latex
Local Anesthetics _____
Narcotics _____
Nitrous
Peanut
Penicillin
Sulfa
Seasonal
Tylenol
Valium/Tranquil
Other _____

MEDICATIONS you are currently taking

No Medications
Antibiotic _____
Antidepressants _____
Anti-inflammatory _____
Aspirin
Birth Control _____
Blood Pressure _____
Blood Thinner _____
Bone Related _____
Cholesterol _____
Cortisone Steroid _____
Heart Medicine _____
Hormone _____
Insulin
Pain Medications _____

Thyroid _____
Ulcer/Nexium _____
Other _____

Medical Information Past & Current

Please circle if applies to you:

Alcoholism/Addiction
Anemia/Excessive Bleeding
Any Transplant
Arthritis
Cancer/Tumor
Circulatory
Diabetes/kidney
Epilepsy/Fainting/Seizures
Fatigue
Glaucoma/Visual
Heart Attack/Stroke
Heart Disease
Heart Murmur
Herpes
Hepatitis
High Blood Pressure
High Cholesterol
Hypoglycemia
Immunocompromised
Infectious Disease
Irregular Heart Beat
Joint Replacement
Mental/Neural
Migraine/Headaches
Nursing/Pregnant
Pacemaker
Prosthetic Implant
Psychiatric Care
Radiation/Chemo
Respiratory/Asthma
Rheumatic Fever
Shingles
Shortness of Breath
Sinus Trouble
Smoke
Swelling
Thyroid/ Hormonal
TMJ
Transmittable Diseases
Tuberculosis
Ulcers/Digestive/Chrohn's Disease
Other _____

The medical information I have provided here is complete. I do not hold any staff members here responsible for any errors or omissions that I may have made during the completions of this information.

_____ _____

Signature Date

Do you have Poor Dental Hygiene? Yes or No
Have you had a Root Canal Before? Yes or No
Do You have to Pre-Medicate for Dental visits & if so what for? _____
Do you have dental anxiety or have you had a bad dental experience? Yes No (If yes, please explain) _____

_____

Health Physicians Name/Number: _____

Print and Sign your name if the person filling out information is not the patient but is the guardian

_____

Informed Consent

I understand root canal therapy is a procedure to retain a tooth which may otherwise require extraction. Although root canal therapy has a very high success rate, 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.

CBCT imaging is an additional charge utilized by our office when beneficial to treatment. This is a separate image from the regular images taken by us and your general dentist.

I understand that CBCT imaging (or 3-D imaging) is an additional charge, that I am responsible for.

Although rare, the following complications may occur in endodontic therapy: pain and swelling, damage to an existing filling or crown, perforation of the root.

I understand that only the root canal treatment or evaluation is to be performed at this office. The outside restoration (such as a crown or filling) will be done by my general dentist.

_____ _____

Signature Date

Financial Arrangements:

Even if you do not have dental insurance, **all patients must read and sign this form**. If you do have dental insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve this goal we need your assistance and understanding of our payment policy. **Your estimated portion is due at the time services are rendered**. We accept cash, check, Visa, MasterCard, Discover, and Care Credit. While we are happy to help process your insurance claim for your insurance savings, we want to emphasize that our relationship is with you, not your insurance company. All charges are your responsibility from the date the services are rendered. Refunds from credit card payments will be subjected to a 2% finance charge. **Returned checks checks will be subject to an insufficent funds fee. Balances older than 30 days will be subject to a minimum finance charge of 10% per month.**

_____ _____

Signature Date

Do you authorize us to release any PHI to any other person? No information, such as treatment plans, appointment changes, or estimates can be given to any other person unless specified below.

*****IF YOU DO NOT LIST THEM, WE CANNOT LEGALLY SPEAK TO THEM ABOUT ANYTHING*****

Name **Relation**

_____

_____

HIPAA

-We are required by applicable federal and state law to maintain the privacy of your personal health information (PHI). We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI. 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 PHI about you for treatment, payment, and healthcare operations. For example, we may use or disclose your PHI to a healthcare provider providing treatment to you or to obtain payment for services we provide to you.

-Your authorization: In addition to our use of your PHI for reasons stated above, you may give us written authorization to use your PHI or disclose it to anyone for any purpose. Unless you give us a written authorization we cannot use or disclose your PHI for any reason except those described in this notice. If you give us an authorization, you may revoke it in writing at any time.

-To your family and friends: We must disclose your PHI to you as described in this notice. We may disclose your PHI 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 PHI 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, prior to use or discloser of your PHI, 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 PHI based on a determination using our professional judgement, disclosing only PHI that is directly relevant to the person's involvement in your healthcare.

-Marketing Health related services: We will not use your PHI for marketing communications or fundraising purposes without your written authorization.

-**Amendment:** You have the right to request that we amend your health information. Your request may be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request, we will provide you with an explanation of why we denied it.

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

-We will notify all patients in the event of a breach of unsecure PHI.

-If a patient pays in full for a service out of pocket, they have the right to request we do not disclose treatment information for this service to a health plan. You, the patient, have the right to an electronic copy of your treatment records.

We can now send secure and non-secure emails to patients of their PHI if: 1. The patient requests, 2. If the email address is verified, and 3. The patient is informed of the possible security risks of emailing sensitive information.

We have updated our privacy policies effective 1/1/2023.

_____ _____

Signature Date