PATIENT INFORMATION

Name:______________________________ Nickname:____________________

Address:______________________________ City:____________________

State:__________ Zip Code:__________ Date of Birth:____________________

Home# :______________ Cell# :______________ Work#:______________

SSN______-_____-______ Email:______________________________

Employer:______________________________ **Occupation:**____________________

PAYMENT FOR TODAY'S SERVICES MADE BY: Cash________ Credit Card __________ CareCredit__________

DENTAL INSURANCE INFORMATION

Primary Dental Insurance: ______________________________ ID/SSN#____________________

Group Number :__________ Policy Holder Name: ______________ DOB: ______________

Secondary Dental Insurance: ______________________________ ID/SSN#____________________

Group Number :__________ Policy Holder Name: ______________ DOB: ______________

PATIENT'S SPOUSE OR PARENT INFO:
(Complete only if patient is NOT the insurance subscriber and/ or is a dependent child)

Name:______________________________ Cell Number:____________________

Address (if different than above):_______ ______________________________

City:______________ State:______________ Zip:______________

DOB:____________________ SSN:____________________

Employer:______________________________

.

x______________________________ x______________________________
(Patient or Guarantor Signature) (Date)

UPDATES: Initials and Date ____________ ____________ ____________ ____________

GENERAL MEDICAL INFORMATION

Patient Name: ____ Age: ______________________________

Physician Name: ____ Referring Dentist:________________________________

Please list any serious illnesses / major surgeries in the last 10 years: ____

____

Describe any current medical treatment:

____

____

List any medications or supplements that you currently take: ____

____

Please circle any of the following conditions you have experienced:

Glaucoma	Hives	Liver Disease	Nervous or Mental Disorder
Heart Disease	Chemotherapy	Hay Fever	Gastro-Intestinal Disease
Rheumatic Fever*	Cancer	Thyroid Disease	High Blood Pressure
Heart Murmur*	Stomach Ulcer	Radiation Therapy	Low Blood Pressure
Lung Disease	Diabetes	Hepatitis, Type:_______	Chronic Sinus Condition
Blood Disease	Epilepsy	Kidney Disease	Artificial Joint Replacement*
Asthma	Arthritis	Lupus	AIDS or AIDS Complex

*Have you been told by a physician that you need antibiotic premedication before ALL dental treatment? Yes ___________ No ______________

ALLERGIES Please read each question carefully before answering. **Are you allergic to Aspirin?** Yes: ___________ No ____________
Are you allergic to Penicillin? Yes: _________ No_____________
Are you allergic to Latex? Yes____________ No_____________

Please list anything else that you are allergic too:

____

Have you ever had a reaction to local anesthetic? ____
Please describe adverse effects to any medications, supplements or anesthesia____

____

General Information:

Can you walk up a flight of stairs without getting out of breath or having chest pains? Yes ___________ No _______
Are you on a medically supervised diet? ___________________________________ Yes ___________ No _______
Do you bruise easily? Yes ___________ No _______
Do you bleed abnormally? Describe: ____ Yes _________ No ________
Is this treatment for injuries sustained in an accident? If so type of accident and date of accident: Yes _________ No ________
____

Are you pregnant? _________________ If yes, how many weeks? _______________ Are you nursing? ___________ Baby's Age________

The above information is true and correct to the best of my knowledge. I will inform Kansas Endodontics of any changes in my health and or medications. I consent to be examined and to have x-rays of my teeth taken.

Signed: ____ Date: ______________________________
(Patient, Parent or Guarantor)

UPDATES: ____________________ ___________________________ __________________________ ______________________________
(Initial and Date)

KANSAS ENDODONTICS, LLC
6231 SW 29TH STREET, SUITE 300
TOPEKA, KANSAS 66614
785-215-8441

By signing, I authorize Kansas Endodontics, LLC to use and/or disclose certain protected health information (PHI) about me to the following family member(s) and/or friends: Please indicate names, relationship and telephone numbers:

1. ____

2. ____

3. ____

This authorization/disclosure is provided so that I can make an informed decision whether to allow release of information. This authorization permits Kansas Endodontics to use and/or disclose any individually identifiable health information about me pertaining to my treatment or to obtain payment for the services provided me. In addition, I can be contacted at the following places and receive messages for the following purposes: **Indicate by circling Y or N for if we may use this contact method. May we text you? Y or N**

Contact Numbers/Email	Confirm Appointment	Discuss Treatment/Billing
Home:_________________________	Y or N	Y or N
Cell:___________________________	Y or N	Y or N
Work: __________________________	Y or N	Y or N
EMAIL: _________________________	Y or N	Y or N

If I agree that the dental practice may communicate with me electronically at the above email address, I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I am responsible for providing any updates to my email address and I can withdraw my consent to electronic communication by calling: 785-215-844 I also understand that this risk may also apply to unencrypted emails sent to any healthcare providers related to my treatment.

I was given an opportunity to read and/or take with me a written copy Kansas Endodontics Notice of Privacy Practices. I do not have to sign this authorization in order to receive treatment from Kansas Endodontics, LLC In fact; I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My revocation must be submitted to the Privacy Officer at Kansas Endodontics, LLC.

PLEASE PRINT THE FOLLOWING:

PATIENT NAME: ____

PARENT/LEGAL GUARDIAN: ____

_______________________________ (SIGNATURE)

_______________________________ (DATE)

TREATMENT AND FINANCIAL CONSENT FORM

- I understand that root canal treatment and the alternative(s) to root canal treatment will be explained to me by my specialist at Kansas Endodontics prior to beginning any treatment.

- Possible risks and complications of root canal treatment include but are not limited to the following: pain; swelling of the gum, jaw or face; trismus (restricted jaw opening); temporary or permanent numbness of the gum, lip or face; infection of the jaw, face or other parts of the body; allergic or other serious or potentially life threatening adverse reactions to medications prescribed or materials used.

- In approximately 5-10% of cases, treatment does not succeed. If failure occurs, the treatment may have to be redone, root-end surgery may be required or the tooth may have to be extracted (taken out.) Small instruments may break during treatment, which may be left in the root or jaw or require surgery for removal. The root may be perforated with instruments which may require additional surgical corrective treatment or result in premature tooth loss or extraction. The tooth may be lost to progressive periodontal (gum) disease in the surrounding area. Another undiscovered tooth in the area may also require root canal treatment. The root of the tooth may break during or after treatment and the tooth will have to be extracted.

- I agree to take all medications prescribed and to promptly report any problems to the office by calling 785-215-8441 I understand that after root canal treatment my tooth will be brittle and must be protected against fracture by a crown (cap) or filling by my general dentist. If this is not done, there is a strong possibility that I will lose the tooth. If my treating dentist recommends, I agree to return in six (6) months for a recall visit so that the doctor can evaluate the root canal treatment and I agree to follow the doctor's recommendations at that time.

FINANCIAL:

- No warranty or guarantee of success has been or can be given in root canal treatment. I acknowledge full responsibility for the payment of such services. I agree that no refund is due if the tooth is lost prematurely or if other complications occur.

- **I understand that if I do not have dental insurance that I am responsible for payment in full at time of treatment. If I do have dental insurance, I am responsible for my estimated portion in full at time of treatment. I also understand there is a $40 returned check fee for any returned checks.**

- **While the staff will make their best attempt to get accurate benefit information, I understand that any balance due after my insurance has paid or if my insurance doesn't pay within 60 days of treatment, that this balance is my responsibility and is due immediately. We are in network with BCBS of Kansas (NOT PPO PLANS), Delta Dental and Aetna . We do not file workmans compensation claims or claims to medical insurance.**

- **I agree to pay any fees or interest charges incurred if my account is referred to a collection agency or attorney for collection.**

- I have read and fully understand the above statements on this "Treatment and Financial Consent" form. I hereby consent to the required treatment to be performed by KANSAS ENDODONTICS and to these financial stipulations. I hereby authorize payment directly to the provider for services rendered and authorize the release of any information needed to process my dental claims.

_______________________________________ (SIGNATURE)

_________________________ (DATE)