HOBEICH ENDODONTICS
Your Root Canal Specialist

Patient Information

Name:_____ **DOB:**_____ **Sex: M F**

Address:_____

City:_____ **State:**_____ **Zip:**_____

Home#_____ **Cell#**_____ **Work#**_____

Employer/phone # _____

RESPONSIBLE PARTY:_____ **Phone #**_____

INSURANCE INFORMATION

DENTAL INS._____

SECONDARY INS._____

GROUP NO._____ **I.D./SS#**_____

POLICYHOLDER IF DIFFERENT FROM ABOVE:

_____

SS#_____ **D.O.B**_____

_____

RELEASE/CONSENT:

This is my consent for the doctors of **HOBEICH ENDODONTICS** to perform any necessary dental procedure(s) as indicated by my dental examination. I understand that although root canal has a high degree of success, it is still a biological procedure, and therefore success cannot be guaranteed. I have been informed and understand that there are certain inherent and potential risks in a treatment procedure. These risks may include, but are not limited to, swelling, infection, bruising, discomfort, and fractures of teeth and existing restorations.

I understand that variations in tooth anatomy and canal shape may complicate treatment and could result in a perforation (hole) in the root or separation of a metal root canal instruments in the tooth. Additional treatment, surgical repair, or extraction may be necessary to resolve these problems.

I have been informed of possible alternative treatments including extraction and non-treatment and the possible benefits or adverse results from these alternative treatments. I understand that a permanent restoration (filling or crown) is to be done within 30 days after completion of the root canal therapy by my restorative dentist. I also understand that failure to have the permanent restoration completed may lead to failure of the root canal therapy as well as possible fracture and/or infection of the treated tooth. This may result in the necessity for additional treatment or extraction of the previously treated tooth.

I understand that root canal therapy is to be rendered if determined diagnostically.

THERE WILL BE A $50.00 FEE APPLIED FOR NO SHOWS AND OR CANCELLATIONS WITHOUT 24HR. PRIOR NOTICE.

PATIENT (GUARDIAN)_____ **DATE** _____ **WITNESS** _____

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MEDICAL HISTORY

*Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. For the following questions, please mark **Yes** or **No**. Please note you may be asked additional questions concerning your health.*

Are you currently under the care of a physician? □Yes □No
Name of Physician:_____ Phone #:_____
Are you currently in good health? □Yes □No
In the last year, have there been any changes in your general health? □Yes □No
My last physical examination was on: _____(mm/yyyy)
If so, what is the condition are being treated for?
_____
Have you had any serious illness or hospitalizations in the last 5 years? □Yes □No
If yes, what was the illness or problem:
_____
Are you currently taking or have your recently taken any prescription or over the counter medicine(s)? □Yes □No
If so, please list all, including vitamins, natural or herbal and/or diet supplements:
_____
_____
_____

Allergies: if YES please specify type of reaction.	
Local anesthetics:_____.	□Yes □No
Aspirin/NSAIDs:_____.	□Yes □No
Penicillin or other antibiotics:_____.	□Yes □No
Barbiturates, sedatives, or sleeping pills:_____.	□Yes □No
Sulfa Drugs:_____.	□Yes □No
Codeine/Narcotics:_____.	□Yes □No
Metals:_____.	□Yes □No
Latex:_____.	□Yes □No
Seasonal Allergies:_____.	□Yes □No
Animals:_____.	□Yes □No
Food:_____.	□Yes □No
Other:_____.	□Yes □No

Please mark (X) your response to indicate if you have or have not had any of the following disease or problems

Heart murmur	□Yes □No	Sinus trouble	□Yes □No
Mitral valve prolapse	□Yes □No	Tuberculosis	□Yes □No
Artificial heart valves	□Yes □No	Cancer/chemo/rad treatment	□Yes □No
Rheumatic fever	□Yes □No	Chest pain upon exertion	□Yes □No
Cardiovascular disease	□Yes □No	Chronic pain	□Yes □No
Angina	□Yes □No	Diabetes type 1 or 2 (A1C _____)	□Yes □No
Arteriosclerosis	□Yes □No	Eating disorder	□Yes □No

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Congestive heart failure	□Yes □No	Malnutrition	□Yes □No
Coronary artery disease	□Yes □No	Gastrointestinal disease (reflux)	□Yes □No
Damaged heart valves	□Yes □No	Heartburn	□Yes □No
Heart attack	□Yes □No	Ulcers	□Yes □No
Low blood pressure	□Yes □No	Thyroid problems	□Yes □No
High blood pressure	□Yes □No	Stroke	□Yes □No
Congenital heart defects	□Yes □No	Glaucoma	□Yes □No
Pacemaker	□Yes □No	Hepatitis/jaundice/liver disease	□Yes □No
Rheumatic heart disease	□Yes □No	Epilepsy	□Yes □No
Abnormal bleeding	□Yes □No	Seizures or fainting spells	□Yes □No
Anemia	□Yes □No	Sleep disorders	□Yes □No
Blood transfusion (Date:_____)	□Yes □No	Kidney Problems	□Yes □No
Hemophilia	□Yes □No	Night sweats	□Yes □No
Arthritis	□Yes □No	Osteoporosis	□Yes □No
Autoimmune disease	□Yes □No	Persistent swollen neck glands	□Yes □No
Rheumatoid arthritis	□Yes □No	Severe headaches/migraines	□Yes □No
Systemic lupus erythematosus	□Yes □No	Severe of rapid weight loss	□Yes □No
Asthma	□Yes □No	Sexually transmitted disease	□Yes □No
Bronchitis	□Yes □No	Excessive urination	□Yes □No
Emphysema	□Yes □No	Do you wear contact lenses	□Yes □No
Neurological disorders (If yes, specify:_____.)			□Yes □No
Mental health disorders (If yes, specify:_____.)			□Yes □No
Recurrent infections (If yes, specify:_____.)			□Yes □No
AIDS or HIV infection (If yes, CD4:_____Viral load:_____.)			□Yes □No
Are you taking, or have taken, and diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen?			□Yes □No
Are you taking or scheduled to take the medications alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?			□Yes □No
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia of Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? If yes when did treatment begin:_____			□Yes □No
Do you use controlled substances (drugs)? (If yes, specify:_____)			□Yes □No
Do you use Tobacco (smoking, snuff, chew, bidis)? (If yes, specify:_____)			□Yes □No
Do you drink alcoholic beverages? If yes, how much in the last 24 hours?_____. How much in a week?_____.			□Yes □No
Join Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Date:_____Any complications:_____.			□Yes □No
Women Only: Pregnant? (If yes, number of weeks: _____.)			□Yes □No
Taking birth control pills or hormonal replacement?			□Yes □No
Nursing?			□Yes □No

If there are others, please describe:_____

_____

_____

Have you ever had problems with previous dental treatment? □Yes □No

If yes, please describe:_____

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HIPAA ACKNOWLEDEMENT

OUR LEGAL DUTY

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 must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/20/2011 and will remain in effect until we replace it. 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 reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. All emails containing treatment information are sent via non-encrypted email, if you choose not to have your information sent via non-encrypted email please notify the staff so the information can be sent using an alternative method.

Payment: 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 to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect, unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: Per your request, 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, but only if you agree that we may do so.

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. Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to you with appointment reminders (such as phone call, emails, voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information). You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost –based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

SIGNATURE: _____ **DATE:**_____

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FINANCIAL AGREEMENT

Thank you for choosing us to provide your endodontic care. We consider it an honor to have been chosen by you. Our philosophy in serving people is to be informative, honest, and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement, please do not hesitate to ask our business office staff.

DENTAL INSURANCE

As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

• Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you and not your insurance company.

• You are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable" all of which vary from one company to another.

Your signature indicates your acceptance of responsibility to pay regardless of our estimate.

• All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and co-payments are due at the time of treatment.

PAYMENT POLICY

• We accept cash, debit cards, Visa, MasterCard, American Express, and Discover. For those who qualify, we also accept Care Credit. Care Credit options allow no interest financing for up to twelve months. If you choose to pay in full, on or before the treatment, a discount will be applied (please ask staff for details).

• After dental insurance has paid its portion, a statement is sent to the mailing address on record, for the remaining balance. Payment is expected within 25 days of the statement date, to avoid finance charges.

• **If the insurance company does not pay in full within 45 days, it will be your responsibility.**

Missed Appointment Fee

• If you need to reschedule or cancel an appointment, you must notify us at lease twenty-four (24) hours in advance to avoid a **missed appointment fee of $50**. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

• Broken appointments prevent others from receiving the dental care they deserve. We take them seriously so please be considerate and inform us in advance if you need to change your appointment.

CONSENT & AUTHORIZATION

I, do hereby authorize dental treatment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understand this document in its entirety, outlining office policies and financial policies of **HOBEICH ENDODONTICS LLC.** Without any reservations, I agree to abide by the policies outlined herein.

Signature_____ Date_____