New York Endodontic Associates

Practice Limited to Conventional & Microsurgical Endodontics

Patient Registration

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Social Security: _____

Address: _____ City, State, Zip Code: _____

Cell Phone: _____ Home Phone: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Email: _____

Pharmacy/Address/Phone Number: _____

Referring Dentist/Phone Number: _____

Emergency Contact

Name: _____ Relationship: _____ Phone Number: _____

Dental Insurance

Primary

Name of Insured: _____ Insured Date of Birth: _____

Insured ID number or Social Security: _____

Employer: _____

Insurance Company: _____

Secondary

Name of Insured: _____ Insured Date of Birth: _____

Insured ID number or Social Security: _____

Employer: _____

Insurance Company: _____

Time 10:33 AM

New York Endodontic Associates

Date 11/22/2024

Medical History

Patient Name: Birth Date: Date Created:

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

☐ Other:

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Yellow Jaundice ◯ Yes ◯ No			

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

New York Endodontic Associates

Practice Limited to Conventional & Microsurgical Endodontics

ENDODONTIC CONSENT AND TREATMENT FORM

We would like to welcome you to our office. It is important that you be informed about various procedures involved in endodontic care. Informed consent is necessary before starting your treatment. Please take a moment to carefully read this form.

REASONS FOR TREATMENT: Endodontic (root canal) therapy is accomplished in an effort to save a tooth which otherwise would require extraction. Treatment is done by standard root canal therapy, or when necessary endodontic surgery.

OTHER TREATMENT CHOICES: These include no treatment at all, waiting for more definitive symptoms to develop, and tooth extraction. The risks involved in these choices may include pain, infection, swelling, loss of teeth, and spread of infection to other areas.

RISK SPECIFIC TO ENDODONTIC THERAPY: Those risks include the possibility of instruments broken within the root canals, perforation/s (extra openings) of the crown or root of the tooth: damage to bridges, existing fillings, crowns, fracture of porcelain, loss of tooth structure in obtaining access to the canals, and cracked teeth. During treatment complications may be discovered which make treatment impossible, or which may require endodontic surgery. These complications may include: blocked canals due to previous fillings or prior root canal treatment, natural calcification/s, broken instruments, curved roots, periodontal disease (gum disease), splits or fractures of the teeth.

OTHER RISKS OF TREATMENT: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (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 rare occasions may be a permanent reaction to injections, changes in occlusion (the bite), jaw muscle cramps and spasms, Tempromandibular joint (TMJ) difficulty, loosening of teeth, referred pain to the ear, neck and neck, nausea, vomiting, allergic reactions, delayed healing, sinus perforations and treatment failure.

MEDICATION: 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.

CONSENT: I, the undersigned, being the patient (parent or guardian of minor patient) consent to the performing of procedures deemed 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 referring and/or regular dentist for a permanent restoration of the tooth involved. This restoration may be crown (cap), jacket, onlay or silver 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.

_____
Name of Patient
(Please Print)

_____
Signature
(Patient/Parent/Guardian)

_____
Date

New York Endodontic Associates

Practice Limited to Conventional & Microsurgical Endodontics

OFFICE PHILOSOPHY

We strive for excellence in every aspect of your dental care, and we will always do our best.

We respect your appointed time, and make every effort to stay on schedule ourselves; however, please understand if we are delayed because of a dental emergency or extended treatment.

If you have an emergency dental problem, you will be seen the same day you call.

FINANCIAL POLICY

Please advise us the day before your appointment if must cancel. Appointment cancellations less than 24 hours prior are subject to a $50.00 cancellation fee.

Payment is due on the day services are rendered unless prior financial arrangements have been made. Patients are responsible for any and all legal fees on past due accounts to include: attorney, court and collection costs.

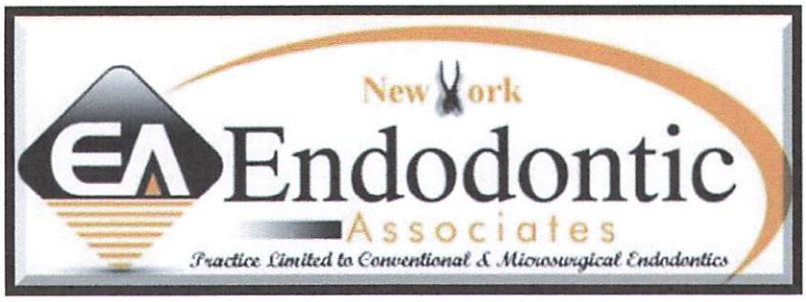
For treatment that requires a substantial investment in your dental health, please feel free to ask us about the several payment plans that we have available.

Sound financial arrangements enable us to deliver more dental care to our patients and help us to keep our fees stable while providing quality dental care.

Please sign and date that you have read, understand and agree to our policy:

_____ _____

Signature Date



POLICY REGARDING INSURANCE ASSIGNMENT

Our office is pleased to accept your insurance assigment. We offer this service as a courtesy to our patients. However, it must be clearly understood that the "contract" is between the patient and the insurance company, the account thereby being the responsibility of the patient for any amount not paid by the insurance company. Following is a statement of our policies governing insurance claims:

1. Although our office does bill the insurance company, it is necessary for the patient to have all of the insurance information forms filled out completely. If this is not completed, we not be able to appropriately bill the insurance company, and the responsibility for payment then becomes that of the patient. We are sorry, but there no exceptions to this policy.

2. We require our patients to sign an "Authorization to Pay The Doctor" form (or any other necessary assignment documents required by your insurance company). By doing so, the insurance company will make payment directly to our office.

3. The patient will pay any co-payments or deductions (the amounts not coverd by the insurance company) as agreed upon the financial consultation.

4. Insurance payments ordinarily are received within 30 to 60 days from the time of billing. If a patient's insurance company has not made payment to our office within 90 days, we may request the patient to pay the balance due, and then seek reimbursement from the insurance company when and if it pays. Our office charges 1 ½ interest compounded each month on past due accounts. Patients are responsible for any and all legal fees to include: attorney, court and collections costs.

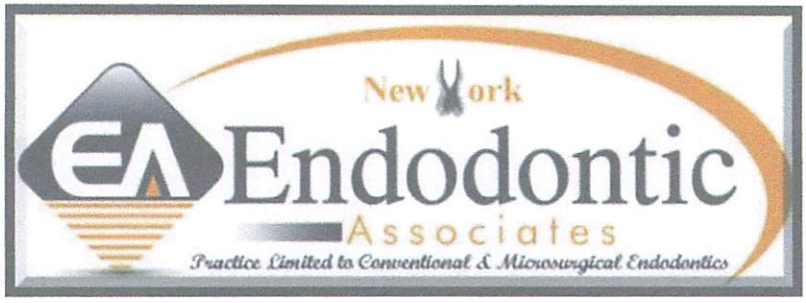
5. Our office does NOT guarantee that the patient's insurance company will pay. We will perform our routine insurance billing procedures and as a courtesy we may perform verification of coverage. However, if for any reason, the patient's insurance claim is denied, the patient is then considered to be responsible for the full amount of the bill.

6. Our office will not enter into a "dispute" with an insurance company over any claims, although we will work with the insurance company to sort out any confusion or questions, which might arise. We cooperate fully with the regulations and requests of the insurance companies. It will be, however, the responsibility of the patient to handle with the insurance company any type of dispute over payment by the insurance company. **The patient is ultimately resposible for the bill.**

IF YOU UNDERSTAND AND AGREE WITH ALL THE ABOVE OFFICE POLICIES, PLEASE SIGN YOUR NAME BELOW AND WE WILL ACCEPT YOUR INSURANCE ASSIGNMENT.

_____ _____

Signature **Date**



NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

Patient Name:_____ **Date of Birth:**_____

I have received this practice's Notice of Privacy Practices written in plain language. This Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliotory actions will be used againts me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practice from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practice and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's currect Notice of Privacy on request.

_____ _____

Signature **Date**