PATIENT REGISTRATION

Date:_____

Check title: Mr. ❑ Ms. ❑ Mrs. ❑ Dr. ❑ Other:_____

First name:_____ Middle initial: _____ Last name: _____

Sex (check): Female ❑ Male ❑ Date of Birth: _____ Social Security #: _____

Home phone:_____ Business phone: _____ Cell Phone: _____

Street:_____

City:_____ State:_____ Zip:_____

Discomfort (check): None ❑ Slight ❑ Moderate ❑ Severe ❑

General Dentist: _____ Referred By: _____
(First and last name) (Please write "same" if referred by general dentist)

Physician: _____ Phone: _____

In case of emergency contact: _____ Phone: _____

Have you ever been a patient of our practice? ❑ Yes ❑ No Method of Personal Payment: ❑ Cash ❑ Check ❑ Credit Card

PRIMARY DENTAL INSURANCE

Employer_____ Bus. Address _____ Bus. Tel.# (___) _____

Plan_____ **Ins. Co. Name** _____ Tel.# (___) _____

Address _____ **Group #** _____ **Group Name** _____

Insured Party _____ Relation _____ Sex: ❑ M ❑ F Date of Birth _____

Street _____ City, State, Zip _____

Tel.# (___) _____ S.S.# _____ I.D.# _____

SECONDARY DENTAL INSURANCE

Employer_____ Bus. Address _____ Bus. Tel.# (___) _____

Plan_____ **Ins. Co. Name** _____ Tel.# (___) _____

Address _____ **Group #** _____ **Group Name** _____

Insured Party _____ Relation _____ Sex: ❑ M ❑ F Date of Birth _____

Street _____ City, State, Zip _____

Tel.# (___) _____ S.S.# _____ I.D.# _____

MEDICAL HISTORY
All Patient Information Is Confidential.

Reason for today's office visit?_____

Do you have any health problems? **Yes** ❑ **No** ❑

If yes, explain: _____

Have there been any changes in your general health in the past year? **Yes** ❑ **No** ❑

Are you under the care of a physician? **Yes** ❑ **No** ❑

If so, for what are you being treated?_____

Date of last medical examination? _____

Have you had any illness, operation or been hospitalized in the past five years? **Yes** ❑ **No** ❑

Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? **Yes** ❑ **No** ❑

If so describe where: _____

Do you have a prosthetic joint? (Knee, hip or any joint replacement)? **Yes** ❑ **No** ❑

If so, describe where: _____

Do you have a heart valve replacement or vascular graft? **Yes** ❑ **No** ❑

If so, describe where: _____

HAVE YOU HAD OR DO YOU CURRENTLY HAVE.....	Yes	No	NOTES	HAVE YOU HAD OR DO YOU CURRENTLY HAVE.....	Yes	No	NOTES
Damaged heart valves / Heart murmur / Mitral valve prolapse				Bruise easily			
Rheumatic Fever / Rheumatic Heart Disease				Jaundice / Hepatitis / Liver disease			
High blood pressure or Low blood pressure				Infectious mononucleosis			
Chest pain / Angina				Gallbladder trouble			
Stroke				Swollen ankles / Arthritis or Joint disease			
Thyroid trouble				Stomach ulcers / Irritable bowl disorder			
Diabetes				Contagious diseases			
Low blood sugar				Sexually transmitted diseases			
Kidney trouble / Dialysis				Immune system problems			
Heart attack(s)				Delay in healing			
Irregular heart beat				Tumor or growth			
Cardiac pacemaker				X-Ray treatment / Chemotherapy			
Heart surgery				Chronic fatigue			
Bronchitis / Chronic cough				Are you on a diet			
Asthma				Do you smoke			
Hay fever / Sinus problems				History of drug abuse / "recreational" drug use (cocaine, etc.)?			
Tuberculosis				Malignant hyperthermia			
Emphysema				Eye disease / Glaucoma			
Difficult breathing / other Lung trouble				Mental health problems			
Blood transfusion				Pain and / or clicking of jaws when eating / TMJ			
Blood disorder such as Anemia				Convulsions / Epilepsy			

MEDICATION

Please list all medicine, drugs, pills, over-the-counter medications you are currently taking:

MEDICATION NAME	NOTES	MEDICATION NAME	NOTES

ALLERGIES

ARE YOU ALLERGIC TO OR HAD A REACTION TO....	Yes	No	Notes	ARE YOU ALLERGIC TO OR HAD A REACTION TO....	Yes	No	Notes
Local anesthetics (Novocaine or Adrenalin)				Codeine or other narcotics			
Penicillin				Other medications			
Other antibiotics				Latex			
Aspirin				**Please list any allergies other than drug allergies:**			

WOMEN

Are you on birth control pills?				Is there a possibility of pregnancy?			
Are you pregnant?				Are you nursing?			
If so, estimated delivery date?							

PLEASE NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician / gynecologist for assistance regarding additional methods of birth control.

Is there any additional condition concerning your health about which the doctor should be told? **Yes** ❑ **No** ❑

Do you wish to speak to the doctor privately about anything? **Yes** ❑ **No** ❑

X _____ Date

X _____ Patient Signature

X _____ Doctor Signature

Advanced Endodontics of New Haven LLC

ROOT CANAL THERAPY CONSENT FORM

I have been been made aware of my condition requiring endodontic (root canal) therapy in the opinion of my dentists. I am aware that the practice of dentistry is not an exact science, and no guarantees have been made to me concerning the result of the procedure.

I understand that an alternative treatment might be (but not limited to) extraction of the involved tooth or teeth. I understand that the consequences of doing nothing will lead to worsening of the condition, further infection, cystic formation, swelling, pain, loss of tooth and / or other systemic diseases and infection problems.

Some complications of the root canal therapy may be, but not limited to:

~ Failure of the procedure necessitating re-treatment, root surgery or extraction.

~ Post operative pain, swelling, bruising and or restricted jaw opening that may persist for several days or longer.

~ Breakage of an instrument inside the canal during treatment, which may be left as is, or may require surgery for removal.

~ Perforation of the canal with instruments, which may require additional surgical treatment or result in the loss of the tooth.

Successful completion of the root canal procedure does not prevent further decay or fracture. An endodontically treated tooth will become more brittle and may discolor. In most cases a full crown is recommended after treatment to lessen the chance of fracture.

By providing my signature, I certify that I understand the recommended treatment, the risks of such treatment, any alternatives and the risks of these alternatives, including the consequences of doing nothing.
I have had a chance to have all my questions answered.

Signature:_____Date:_____

Advanced Endodontics of New Haven

Restoration of Tooth after Root Canal Treatment

As we all know that keeping the root canal system bacteria free is what's responsible for the success of a root canal treatment.

Please be aware that after the root canal treatment, a temporary filling is placed in the access of the tooth for protection against oral contamination. The patient is RESPONSIBLE for scheduling with his or her general dentist for the placement of a permanent filling or crown.

Failure to do so in a timely manner (usually within 1 month) can result in re contamination of the root canal from temporary filling leakage. This re contamination can then lead to re infection of the tooth and the need for subsequent re treatment by the Endodontist.

This office will NOT be responsible for the cost of re treatment if the tooth is not properly restored in a timely fashion after the root canal procedure.

Signature_____Date_____**Advanced**

Endodontics of New Haven

INSURANCE BENEFITS

1. Very few insurance companies cover 100% of dental procedures.

2. If your insurance company does not cover a procedure, that does not mean that the procedure is not appropriate. What it does mean is that the insurance company has limited what it will pay for in coordination with benefits your employer has set up for your company.

3. WE will submit insurance claims for you however; the insurance contract is between you and your insurance company.

4. You are RESPONSIBLE for paying any balance due beyond what your insurance company pays.

5. This office participates with:

ANTHEM BLUE CROSS / BLUE SHIELD

CIGNA PPO ONLY

DELTA DENTAL

6. Pre Estimates are NOT a guarantee of payment. They are only an "estimate" of what your insurance company will cover. There are also deductibles and calendar year maximums.

7. It is in your best interest if you fully understand what your dental insurance covers and what it does not cover.

8. On any procedure done in this office, the patient's portion is due in full at the completion of treatment. WE do not make payment arrangements. Accounts are turned over for collections after the 3rd month of billing. You will receive a final bill and notification. If you are in collections there will be a 1.5% surcharge added on the balance.

Signature _____Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****you may refuse to sign this acknowledgment****

I, _____ have seen a copy of this office's Notice of Privacy Practices. (located in waiting room)

_____
(Please print name)

_____
(Signature)

_____
(Date)

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

*individual refused to sign
*Communications barriers prohibited obtaining the acknowledgement
*an emergency situation prevented us from obtaining acknowledgement
*Other (please specify)

_____
_____
_____