

Welcome to



St. Croix Endodontics, PA

Patient Information

Date _____

Name _____ Sex: M F

Address _____ Home Phone _____

City _____ State _____ Zip _____

Soc Sec. # _____ Birthdate _____

Cell Phone _____ Minor Married Single Divorced Widowed

Employer _____ Work Phone _____

Spouse's Name _____ Birthdate _____

Emergency Contact _____ Phone _____

Person Responsible for Account _____

If student, name of college/school _____

Primary Insurance

Policy Holder's Name _____ Relationship _____

Birthdate _____ Soc. Sec. # _____

Employer _____ Insurance Company _____

Subscriber I.D. _____ Group # _____

Address _____ City _____ State _____ Zip _____

Secondary Insurance

Policy Holder's Name _____ Relationship _____

Birthdate _____ Soc. Sec. # _____

Employer _____ Insurance Company _____

Subscriber I.D. _____ Group # _____

Address _____ City _____ State _____ Zip _____

Medical History

Please take a few minutes to answer the following questions so we can better assist you with your health care needs.

Referring Dentist _____ Medical Doctor _____

Are you currently under medical treatment? If so, please describe _____

Are you currently taking any medications? If so, please list _____

Have you had any allergic reactions to the following? If yes, please list what kind and type of reaction, otherwise check No box.

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Local anesthetic (eg., novocaine) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other antibiotics _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Sulfa drugs _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates (eg., phenobarbital) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Sedatives (eg., Valium) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Iodine _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Aspirin _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Metals _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

Please check the box if you have ever had the following?

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Blood disease |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Kidney disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur | <input type="checkbox"/> | <input type="checkbox"/> | Chemical dependency |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart problems | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Joint replacement |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/Aids | <input type="checkbox"/> | <input type="checkbox"/> | Mitral valve prolapse |
| <input type="checkbox"/> | <input type="checkbox"/> | Back problems | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Do you need to be premedicated? |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Do you take oral contraceptives? |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? |

I certify that I have read and understand the above information and the questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care. To third party payers and/or health practitioners, I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier **may pay less** than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____
Signature of patient or parent/guardian of minor

X _____
Doctor's Signature



All patients are required to sign this prior the initiation of the indicated treatment; however, **it does NOT commit you to treatment.** Endodontic therapy involves removal of the softer center portion of the tooth called the pulp with small metal instruments through an access created in the top portion of the tooth (crown). The resulting space inside the center portion of your tooth is filled with a rubber like material and cement to seal the canals of the root. The root(s) of the tooth remain to anchor the tooth in your jaw. Endodontic therapy requires from 1 to 3 appointments depending on the degree of infection/inflammation and the degree of treatment difficulty. It is important that you maintain scheduled appointments otherwise complications may arise. The purpose of this treatment is to treat and possibly maintain diseased tooth and/or tissue in my mouth that would have been otherwise extracted or lost.

I understand there are **alternatives to endodontic (root canal) therapy.** They include but are not limited to:

- **No treatment at all.** My present oral conditions may worsen with time, and the risks to my health may include but are not limited to: pain, swelling, infection, cyst formation, loss of supporting bone and premature loss or tooth/teeth.
- **Extraction with nothing to fill the space.** This may result in: shifting of the teeth, change in bite or periodontal disease.
- **Extraction followed by a bridge, partial denture or implant to fill the space.**
- **Endodontic surgery.** In the case of retreatment (for a previously unsuccessful endodontic therapy), endodontic surgery may also be an option.

I understand that there are certain **potential risks and complications** in any treatment. They include but are not limited to:

- **Postoperative discomfort** or sensitivity lasting a few hours to several days, which may last longer and radiate to other areas, with intensity from slight extreme. Most commonly the tooth is temporarily sensitive to biting following each appointment alone with mild to moderate localized discomfort in the areas. Sometimes healing is delayed.
- **Postoperative swelling,** infection in the vicinity of the treated tooth, facial swelling, and/or discoloration of tissues which may persist for several days or longer. A small incision may be required to drain swelling.
- **Restrictive mouth opening,** jaw muscle spasm, jaw muscle cramps, temporomandibular joint difficulty, or change in bite, which occurs infrequently and usually lasts for several days but may last longer.
- **Failure rate of 5-10% under optimal conditions.** If failure occurs, additional treatment will be required such as: retreatment, endodontic surgery or extraction of the affected tooth. Retreatments, (of previously unsuccessful endodontic therapy) failure rates are higher, but vary because of reason of failure.
- **Additional therapy.** For some teeth, conventional endodontic (root canal) therapy alone may not be sufficient and additional treatment may be required. For example:
 - If the canal(s) are severely bent, calcified/blocked or split such that they cannot be treated.
 - If an endodontic instrument separates (breaks) in the tooth during treatment.
 - Periodontal (gum) disease or problems in which periodontal treatment may be needed.
 - Pre-existing fractures/cracks, or perforation of the tooth.In some cases, follow-up visits may be recommended while in others an endodontic surgical procedure, extraction or other treatment may be required to resolve the problem. The doctor will explain the options available.
- **Restoration (crown) damage.** If your tooth has a crown, damage such as porcelain fracture may occur while preparing an access opening. If damage occurs or another problem is found such as a cavity, it may require replacement of the restoration. Rarely a restoration may be loosened.
- **Altered sensation** of the lip, chin, cheek and/or gums can result from the use of instruments, materials, medications, anesthetics and injections. This is very rare and usually temporary, but may be permanent.

I understand that after endodontic therapy, my tooth may require an additional restoration (filling, onlay, crown or bridge). I realize that should I neglect to return to my restorative (family) dentist for the proper restoration within one month that there is an increase risk of 1) failure of the endodontic therapy, 2) fracture of tooth and/or, 3) premature loss of tooth.

I understand that I am to **return to this office periodically for a re-evaluation visit, usually every 6-12 months for at least 2 years.** The purpose of this visit is to monitor the endodontic treatment for healing and recommended further treatment as may be needed. Teeth treated with endodontic therapy can still decay. As with other teeth the proper care of these teeth consists of good home care, sensible diet, and periodic check-ups.

No guarantee of success or a perfect result has been given to me. I understand the proposed treatment may not be curative and/or successful to my complete satisfaction. The doctor has explained to me the diagnosis, method and manner of the proposed procedure(s), the nature and purpose, prognosis, risks of treatment and feasible alternatives. I consent to endodontic (root canal) therapy and the administration of local anesthetic. I may request oral sedation, and/or nitrous oxide analgesia. I understand this consent form and it does not encompass the entire discussion regarding the proposed treatment I had with the doctor. I have had the opportunity to question the doctor concerning the nature of treatment, the inherent risks of treatment, and the alternatives to this treatment.

Patient or legal guardian

Date _____



Financial Agreement Record

Patient Name _____ Account Number _____

Treatment Plan:

Estimated Charges \$_____ Initial Payment \$_____ Final Charges \$_____

1. Patients without dental benefits

- Cash or check for payment in full. We will extend 5% bookkeeping savings.
- Credit Card. If you pay with credit card, no cash bookkeeping savings will be extended.
- Care Credit. For patients who choose not to use a credit card you may apply for financing through our office. Please inquire about interest free options. Applications are available in our office or you may apply on the Care Credit website at carecredit.com prior to your appointment.

2. Patients with dental benefits (Please select one)

- A. Payment in full of all fees at time of service and have any insurance benefits sent directly to you. Save 5% for payment in full with cash or a check.
B. Financing through our office with Care Credit. Please inquire about interest free options. Applications are available in our office or you may apply on the Care Credit website at carecredit.com prior to your appointment.
C. If you want to pay your initial payment today with cash, check or credit card, St. Croix Endodontics is asking you to secure the remaining balance with a credit/debit card on file until your insurance pays. St. Croix Endodontics will notify you by mail after 45 days if your insurance company has not paid. Any outstanding balance after 60 days is applied to the card on file unless other arrangements have been made.

- Care Credit
- Visa
- Master Card
- Discover

Table with 15 columns and 1 row, containing dashes in the 5th, 9th, and 13th columns.

Signature

Exp. Date

Date

All accounts must be paid in full within 60 days from the date of service.

This includes balances incurred by untimely insurance payment(s) and/or insurance denials. All accounts over 60 days will be turned over to a collection department unless other payment arrangements have been made. If untimely payments are received while the account is in collections, the patients and/or responsible party will be held liable for any and all finance charges and collection agency fee.

There will be a \$32 fee for any returned checks. There will be a \$27 administrative fee for any patients turned over to collections.

Signature of Responsible Party

Date



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Birth Date: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice if Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: HIPAA OFFICER

Telephone: 763-767-9119 / 1-888-281-2633 Fax: 763-755-3797

Address: 11855 Ulysses Street, Suite 260, Blaine, MN 55434

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Print Signature:

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.