Hawaii Endodontics

WELCOME TO OUR PRACTICE

PATIENT REGISTRATION FORM

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Last Name _____ First Name _____ M.I. _____

Gender: ☐ Male ☐ Female Birth Date: ____/_____/_____ Age: _____

Home Address: Street _____ City _____ State _____ Zip _____

Billing Address: Street _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

If a Child, Parent/Guardian Name: _____ Who will be responsible for financial? _____

Employer _____ Business Phone _____ Occupation _____

Family Dentist _____ Phone Number _____ Referring Dentist _____

Medical Doctor _____ Phone Number _____ Last visit _____

Emergency Contact Person _____ Phone _____ Relationship to Patient _____

MEDICAL HISTORY

Are you currently under the care of a Physician? ☐ Yes ☐ No IF Yes, Please explain _____

Do you have any history of the following? ☐ Yes ☐ No IF Yes, Please check the appropriate boxes.

- ☐ Rheumatic Fever
- ☐ Heart Murmur / Mitral Valve Prolapse
- ☐ High Blood Pressure
- ☐ Heart Attack(s)
- ☐ Heart Trouble/ Heart Disease
- ☐ Pace Maker
- ☐ Kidney Trouble
- ☐ Stomach Ulcers
- ☐ Asthma
- ☐ Sinus Problems
- ☐ Mental Health Problems
- ☐ Tuberculosis
- ☐ Drug/Alcohol Abuse
- ☐ Bleeding Disorder
- ☐ Hepatitis
- ☐ Thyroid Problems
- ☐ HIV / AIDS
- ☐ Convulsions / Epilepsy
- ☐ Diabetes
- ☐ Cancer
- ☐ Radiation / Chemotherapy
- ☐ Arthritis
- ☐ Joint replacement / Implant(s)
- ☐ Osteoporosis

Are you required to take antibiotics before dental visits? ☐ Yes ☐ No

Do you take daily Aspirin or blood thinner? ☐ Yes ☐ No

Do you take Osteoporosis medications (i.e. Fosamax, Actonel)? ☐ Yes ☐ No

IF Yes, which medication?_____

Are you sensitive or Allergic to any Medications/Anesthetics/Latex? ☐ Yes ☐ No

IF Yes, to What? _____

WOMEN: Are you Pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

Note: Antibiotic may alter the effectiveness of birth control pills. Please consult your physician.

List of current medications: ☐ None

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HIPAA NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

Thank you for reviewing our HIPAA Notice of Privacy Practice.

Please sign below to to acknowledge that a copy of Notice of Privacy Practices has been made available for your review and you have been given the opportunity to ask any questions regarding this Notice.

INSURANCE RELEASE AND FINANCIAL POLICY

If you have any dental and/or medical insurance, we will be glad to fill out the proper forms for claim. It is your responsibility to pay any deductible amount, all “patient portions”, any non-covered services, as well as any charges exceeding patient’s maximum. **All payments for services are your responsibility and are due at the time of service.** If you default in making payments for the services, your account will be assigned to a collection agency. You will be responsible for all collection costs, attorneys fees, and court costs.

Signature of Patient (Parent/Guardian if a Minor) _____ Date: ___/___/____

Hawaii
Endodontics

CONSENT FOR (SURGICAL / NON SURGICAL) ENDODONTIC THERAPY

Please Review the following consent. You will be required to sign it prior to initiation of the indicated treatment, however, ***it does NOT commit you to treatment***. Please review these possible risks and complications,which however rare, can occur from endodontic treatment.

Local anesthetic risks include allergic reactions, rapid heart beat, lightheadedness, fainting, swelling, bruising, or jaw muscle cramps and jaw joint difficulties. Prolonged numbness and tingling, although rare, may be permanent in some cases. Please avoid eating until the local anesthetic has worn off.

Non Surgical Endodontic therapy has a very high degree of success, but results cannot be guaranteed. Occasionally, a tooth, which has had root canal therapy, may require retreatment, surgery, or even extraction. Following treatment, the tooth may be brittle and subject to fracture. A restoration (filling), crown and/or post and core will be necessary to restore the tooth, and your general dentist will perform these procedures. During endodontic treatment, there is the possibility of instrument separation within the root canals, perforations (extra openings), damage to bridges, existing fillings, crowns or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals, and fractured teeth.

I am aware that complications of Surgical Endodontics and anesthesia may include the following: pain, swelling, trismus (restricted jaw opening), infection, bleeding, sinus involvement, osteonecrosis of jaw, numbness or tingling of the lip, gum or tongue, which rarely are protracted, and even more rarely, are permanent. I understand that it is my responsibility to report any symptoms to Hawaii Endodontics immediately.

Other treatment choices include no treatment, a waiting period for more definitive symptoms to develop, or tooth extraction. Risks involved in those choices might include, but are not limited to, pain, infection, swelling, loss of teeth, and infection to other areas

Common side effects from medications include nausea and stomach upsets, allergic reactions such as swelling or itching. Prescription medications may cause drowsiness, lack of awareness, poor coordination or poor judgment. Do not consume alcohol or other drugs because they may increase these effects. Do not work or operate any vehicle, automobile or hazardous device until fully recovered from the effects of the medications.

If any of these problems occur, call Hawaii Endodontics immediately. It is the patient's responsibility to report any changes in his/her medical history to Hawaii Endodontics.

It has been explained to me, and I understand, that a perfect result from Endodontic Therapy is not guaranteed. I have been given the opportunity to ask any questions concerning the nature of the treatment, the inherent risks of the procedure(s), and the alternative(s) to such treatment(s).

AUTHORIZATION AND CONSENT TO SEND UNENCRYPTED PATIENT INFORMATION BY EMAIL AND OTHER ELECTRONIC MEANS

Until I tell you in writing to stop, I authorize Hawaii Endodontics to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or Hawaii Endodontics health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records. If I don't sign this form, Hawaii Endodontics may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself. There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be redisclosed and no longer protected by privacy law. I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Hawaii Endodontics already sent before receiving my written instructions to stop.

PLEASE SIGN BELOW TO ACKNOWLEDGE THAT YOU READ CONSENT FOR ENDODONTIC THERAPY AND AUTHORIZATION AND CONSENT TO SEND UNENCRYPTED PATIENT INFORMATION BY EMAIL AND OTHER ELECTRONIC MEANS.

Patient Name (Please Print) _____

Signature of Patient (Parent/Guardian if a Minor) _____ Date: ____/___/_____