# Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you.

We look forward to working with you in maintaining your dental health.

## Patient Information

Name_____ Soc. Sec. #_____
Last Name First Name Initial

Address _____

City_____ State_____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ☐F ☐M Age _____ Birthdate _____ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorce

Nickname: _____

Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

## Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (*if different from patient*) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

## Additional Insurance

Is patient covered by additional insurance? ☐Yes ☐No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (*if different from patient*) _____ Soc. Sec. # _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Business Address _____ Business Phone _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber # _____

# Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Current Dentist _____ Address _____

Dentist's Email _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check yes or no if you have had problems with any of the following:

| | | |
|---|---|---|
| ☐Y ☐N Bad breath | ☐Y ☐N Food collection between teeth | ☐Y ☐N Periodontal treatment |
| ☐Y ☐N Sensitivity to sweets | ☐Y ☐N Bleeding gums | ☐Y ☐N Grinding or clenching teeth |
| ☐Y ☐N Sensitivity to cold | ☐Y ☐N Sensitivity when biting | ☐Y ☐N Clicking or popping jaw |
| ☐Y ☐N Loose teeth or broken fillings | ☐Y ☐N Sensitivity to hot | ☐Y ☐N Sores or growths in mouth |

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with the medical or dental procedure? ☐Y ☐N

Other information about your dental health or previous treatment _____

# Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? ☐Y ☐N

If yes, describe _____

Are you currently under physician care? ☐Y ☐N If yes, describe _____

Have you ever had a blood transfusion? ☐Y ☐N If yes, describe _____

Have you ever taken Fen-Phen/Redux? ☐Y ☐N

Women: Are you pregnant? ☐Y ☐N Nursing? ☐Y ☐N Taking birth control pills? ☐Y ☐N

Check yes or no whether you have had any of the following:

| | | |
|---|---|---|
| ☐Y ☐N Current Med Trt | ☐Y ☐N Cancer | ☐Y ☐N Infectious Diseases |
| ☐Y ☐N Dry Mouth | ☐Y ☐N Radiation/Chemo | ☐Y ☐N Venereal Diseases |
| ☐Y ☐N High Blood Pressure | ☐Y ☐N Tuberculosis | ☐Y ☐N Psychiatric Care |
| ☐Y ☐N Respiratory/Asthma | ☐Y ☐N Fatigue | ☐Y ☐N TMJ/Jaw |
| ☐Y ☐N Rheumatic Fever | ☐Y ☐N Swelling | ☐Y ☐N Heart Disease |
| ☐Y ☐N Hypertension/Circula | ☐Y ☐N Overweight | ☐Y ☐N Heart Murmur/Defect |
| ☐Y ☐N Immunocomprised | ☐Y ☐N Underweight | ☐Y ☐N Pacemaker |
| ☐Y ☐N Anemia/Bleeding | ☐Y ☐N Ulcers/Digestive | ☐Y ☐N Heart Attack/Stroke |
| ☐Y ☐N Diabetes/Kidney | ☐Y ☐N Migraine/Headaches | ☐Y ☐N Systemic Lupus |
| ☐Y ☐N Herpes | ☐Y ☐N Epilepsy/Fainting | ☐Y ☐N Prosthetic Implant |
| ☐Y ☐N Thyroid/Hormonal | ☐Y ☐N Glaucoma/Visual | ☐Y ☐N Any Transplant |
| ☐Y ☐N Hypoglycemia | ☐Y ☐N Mental/Neural | ☐Y ☐N Joint replacement |
| ☐Y ☐N Smoke/Tobacco | ☐Y ☐N Tumor/Neoplasms | ☐Y ☐N Arthritis |
| ☐Y ☐N Shortness of Breath | ☐Y ☐N Alcoholism/Addiction | ☐Y ☐N Pregnant/Nursing |

Is patient currently taking any medications? If yes, list all: Does patient have drug allergies? If yes, list all:

_____ _____

_____ _____

## Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorized the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

**Payment is due in full at time of treatment, unless prior arrangements have been approved.**

# NOTICE OF PRIVACY PRACTICES

(DENTAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEWIT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be if interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by representing a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice for us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of November 18, 2013 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse of you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

For more information about HIPAA
Or to file a complaint:

The U. S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D. C. 20201
(202)619-0257
Toll Free: 1-877-696-6775

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Abide Endodontics
5740 Getwell Road
Bldg. 3A
Southaven, MS 38672
662-470-5811

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Official use only

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgement,* but was unable to do so as documented below.

Date: _____ Initials: _____ Reason: _____

# ABIDE ENDODONTICS

Andrew E. Abide, JR, D.M.D.
5740 Getwell Rd., Bldg. 3A
Southaven, MS 38672
662-470-5811

## FINANCIAL POLICY

1.) As a courtesy to our patients we will file on your primary insurance at no cost. Your portion is due the day services are rendered. If you have secondary insurance then this is your responsibility to file after your primary insurance has paid. Some insurance companies select to send the insured person the check. If you get the insurance check you are held responsible to sign the back and bring it in immediately to satisfy your account balance.

2.) We take Checks, Cash, Debit Cards, Visa, MasterCard, Discover and American Express.

3.) Care Credit applications are also available to fill out for major dental work needed. They carry accounts for six, twelve, eighteen and twenty-four months at no interest and no finance charges. You may also call them at 1-800-365-8295 from home for approval.

4.) We will charge up to 18% finance charge on all accounts over 30 days or more past due.

5.) Payment is due day of service.

**Any delinquent accounts not collected will be charged a 40% increase by our office to take care of collection fees and legal cost.**

Thank you so much for understand our new policy.

Signature of Responsible Party: _____

Date: _____

**ABIDE ENDODONTICS**
Accounting Department

ABIDE ENDODONTICS
Andrew Abide, Jr., D.M.D.
5740 Getwell Rd. Bldg. 3A
Southaven, MS 38672
662-470-5811

# ENDODONTIC INFORMATION AND CONSENT FORM

*Please be reassured that we use accepted infection control procedures and universal precautions for the protection of our patients and staff.*

## Endodontic Root Canal Therapy, Endodontic Surgery, Anesthetics & Medications

While serious complications associated with root canal therapy are very rare, we would like our patients to be informed about the various procedures in endodontic therapy and have their consent before starting treatment. Endodontic (root canal) therapy is performed in order to save a tooth which might otherwise need to be removed. Root canal therapy is completed in one or more appointments. This is accomplished by conservative root canal therapy or, when needed, endodontic surgery. The objectives of this treatment are: to relieve pain and infection, if present, remove the diseased pulp tissue, and clean, disinfect and fill the root canals. Radiographs and local anesthetics will be required during the treatment. Antibiotics and analgesics may also be needed. The following possible risks may occur at any time during endodontic treatment.

**Risks:** Complications resulting from, but not limited to, the use of dental instruments, drugs, sedation, medicines, anesthetics, and injections. These complications include: swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensations in the lip, tongue, chin, gum, cheeks and teeth, which is transient but on occasions may be permanent reactions to injections, changes in occlusion (biting), jaw muscle cramps and spasms, temporomandibular (jaw) joint difficult, referred pain to ear, neck and head, nausea, vomiting, allergic reactions, delayed healing, sinus perforations, and treatment failure.

**Risks More Specific to Endodontic Therapy:** The risks include the possibility of instruments broken within the canals, perforations (extra openings) of the crown or root of the tooth, damage to bridges, existing fillings, crowns or porcelain veneers, loss of tooth structure in gaining access to the canals and cracked teeth. During treatment complications may be discovered which make treatment impossible or which may require dental surgery. Such complications may include blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal (gum) disease, and splits or fractures of the teeth. Cases started in other offices or re-treatment cases are usually more difficult and may have a different outcome than expected under normal conditions.

**Medications:** 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.

**Women Taking Birth Control:** Antibiotics such as penicillin, tetracycline, or others, may diminish the effectiveness of birth control medication. For this reason, **additional contraceptive measures are recommended during the time on which any antibiotics are being used.**

**Other Treatment Choices:** These include no treatment, waiting for more definite development of symptoms, or tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infections to other areas.

_____

Patient, parent or guardian Date

_____

Witness Doctor

# CONSENT

I, the undersigned, being the patient (parent or guardian of above minor patient), acknowledge that I have read this form and consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. 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 that has had root canal therapy may require re-treatment, surgery or extraction at an additional fee.

If health care workers are accidentally exposed to my blood or other bodily fluids in the course of providing treatment to me, I agree to have my blood tested for any infectious diseases which might be transmitted to them through this exposure, including HIV / AIDS and hepatitis.

**I also understand that, upon completion of root canal therapy in this office, I should return to my general family dentist for a permanent restoration of the tooth involved.**

_____

Patient, parent or guardian Date

_____

Witness Doctor