ENDODONTISTS SPECIALISTS
60 WASHINGTON AVENUE, SUITE 202, HAMDEN, CT 06518 203-281-6574
406 ORANGE STREET, NEW HAVEN, CT 06511 203-777-6461

NAME/MS. DATE _____/_____/_____
MISS/MR.
MRS./DR. _____ SS# _____--_____--_____
LAST MI FIRST

ADDRESS_____ DATE OF BIRTH _____/_____/_____
STREET CITY/TOWN ZIP

HOME PHONE ( )_____ CELL ( )_____ E-MAIL_____

OCCUPATION_____PLACE OF WORK_____ WORK PHONE ( )_____

REFERRING DENTIST_____
NAME CITY/TOWN

CONTACT IN CASE OF EMERGENCY_____ RELATIONSHIP_____ PHONE( )_____

REASON FOR THIS VISIT _____

CHECK IF YOU HAD BEEN CARED FOR BY ANY OF THE FOLLOWING:

☐ ORTHODONTIST ☐ PERIODONTIST ☐ ORAL SURGEON ☐ OTHER NAME _____

PHYSICIAN'S NAME_____ PHONE ( ) _____

ARE YOU NOW OR HAVE YOU RECENTLY BEEN UNDER A PHYICIAN'S CARE? Y / N

IF YES, FOR WHAT REASON _____

CHECK IF YOU ARE ON ANY OF THE FOLLOWING MEDICATION:

☐ STEROID ☐ SYNTHROID ☐ COUMADIN ☐ PLAVIX ☐ ASPIRIN

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, IF ANY _____

_____

CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

☐ DIABETES	☐ CONGENITAL HEART DEFECT	☐ HERPES
☐ ALLERGIES	☐ RHEUMATIC FEVER	☐ HIV
☐ ASTHMA / HAY FEVER	☐ HEART MURMUR	☐ STROKE
☐ SINUS PROBLEM	☐ MITRAL VALVE PROLAPSE	☐ DIZZY SPELLS / SEIZURES
☐ EAR INFECTION	☐ ARTIFICIAL VALVE	☐ EPILEPSY
☐ TUBERCULOSIS	☐ PACE MAKER	☐ NEUROLOGICAL DISORDER
☐ LUNG DISEASE	☐ IRREGULAR HEARTBEAT	☐ GLAUCOMA
☐ PNEUMONIA	☐ HEART ATTACK WHEN _____	☐ DRUG OR ALCOHOL ADDICTION
☐ LIVER DISEASE	☐ HEART SURGERY	☐ PSYCHIATRIC TREATMENT
☐ HEPATITIS / JAUNDICE	☐ ABNORMAL BLEEDING	☐ CANCER _____
☐ SLOW HEALING	☐ HIGH BLOOD PRESSURE	☐ CHEMOTHERAPY
☐ KIDNEY DISEASE	☐ LOW BLOOD PRESSURE	☐ RADIATION THERAPY
☐ STOMACH ULCERS	☐ ANEMIA	☐ MAJOR OPERATION _____
☐ THYROID DISEASE	☐ ARTHRITIS	☐ PROSTHETIC JOINTS WHEN _____

☐ OTHER _____

CHECK IF YOU HAVE HAD SENSITIVITY OR ALLERGIC RESPONSE TO ANY OF THE FOLLOWING:

☐ LOCAL ANESTHETICS ☐ EPINEPHRINE ☐ ASPIRIN ☐ CODEINE ☐ LATEX ☐ IODINE ☐ ANTIBIOTICS _____

☐ OTHERS _____

HAVE YOU EVER TAKEN ANTIBIOTICS BEFORE DENTAL PROCEDURES? Y / N NAME _____

DO YOU SMOKE TOBACCO? Y / N IF YES, HOW MUCH? _____

WOMEN ONLY: ARE YOU PREGNANT? Y / N HOW MANY MONTHS? _____ ARE YOU BREAST FEEDING? Y / N

PLEASE INDICATE ANY SPECIAL CONCERNS RELATED TO YOUR DENTAL TREATMENT _____

_____

I HAVE REVIEWED THE INFORMATION ON THIS QUESTIONNAIRE AND IT IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____/_____DATE ___/___/_____
SIGNATURE OF PATIENT OR PARENT IF PATIENT IS A MINOR OR RESPONSIBLE PARTY RELATIONSHIP TO PATIENT

REV - 1/10

Endodontics
60 Washington Avenue, Hamden, CT 06518
Phone (203) 281-6574 FAX (203) 281-1045

PATIENT BILLING AND DENTAL INSURANCE INFORMATION

Financially Responsible Party (Name)_____ SS#____/____/____

Patient (Print Name) _____ SS#_____/_____/____

Financially Responsible Party (Address) _____

City State Zip

DENTAL INSURANCE COMPANY INFORMATION (**If you do not have dental insurance to cover endodontic services, please proceed to the AUTHORIZATIONS AND FINANCIAL AGREEMENT)**

Name of the Dental Insurance Company: _____

Address: _____

City State Zip

Subscriber Name (Print) _____

a. Date of Birth (MM/DD/CCYY) ____ /____/____

b. Address _____

City State Zip

c. Subscriber Identifier (SSN or ID#) _____

d. Plan / Group Number _____

e. Employer Name _____

Employer Address_____

City State Zip

Patient's Relationship to Primary Subscriber (Please Circle Below)

Self Spouse Dependent Child Other (Explain) _____

AUTHORIZATIONS

I authorize insurance payments be made directly to the doctor for services rendered and understand that I am financially responsible for charges regardless of insurance coverage. To the extent permitted by law, I consent to the release of protected medical information to third parties as specified by HIPAA laws regarding Privacy Practices for the purpose of enabling the doctor to obtain payment for dental services rendered. I understand that if the third party is not a health care provider the released information may no longer be protected. I understand that I may revoke this authorization at any time and that it will automatically terminate one year from the date the dental services have been completed.

Patient's or Guardian's Signature: _____ Date___/___/____

Financially Responsible Party's Signature _____ Date____/___/____

FINANCIAL AGREEMENT

I agree that I am financially responsible for all services rendered by the doctor regardless of insurance coverage. Payment in full is due at the time dental services are rendered, unless other payment arrangements have been approved in writing in advance by our staff. I agree that all balances 30 days past due (after all insurance claims are processed) are subject to late charges at the rate of $10.00 per month. I agree to pay reasonable attorney's fees as limited by law and all costs of collection in case of default on payment of the account. **I hereby certify that I have read and understand this form, and have received a copy of this document.**

Financially Responsible Party's Signature _____ Date___/____/____

Endodontics, LLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on April 10, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may

disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.10 for each page, $15 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Dr. Bruce Y. Cha Address: 60 Washington Avenue, Hamden, Connecticut 06518

Telephone: 203 281-6574 Fax: (203) 281-1045 E-mail: Hamden@rootcanaldrs.com

Endodontics, LLC

Notice of Potential Risks of Endodontic Treatment / Surgery

Please read the following information on inherent and potential risks of the endodontic treatment and/or surgery. The doctor will answer any questions or concerns you might have during the consultation and examination.

Root canal treatment procedure is usually safe and yields successful outcome in most of the cases. However, there are inherent and potential risks involving the procedure. The incidence of these risks to occur is extremely low. Our doctor and staff will pay utmost attention to ensure that these potential risks will not occur during the treatment. However, we should inform the patient that they exist. The risks involved with endodontic treatment/surgery include, but are not limited to:

swelling; prolonged sensitivity; bleeding; pain; infection; numbness and/or tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is transient but on infrequent occasions may be permanent; reactions to injections; change in occlusion (biting); jaw muscle cramps and spasm; temporomandibular joint difficulty; loosening and/or breakage of teeth, crowns or bridges; referred pain to ear, neck and head; delayed healing; perforation of the tooth; sinus perforation; treatment failure; loss of the tooth; additional root canal treatment of another tooth; resorption*; ankylosis**; complications resulting from the use of dental instruments (broken instruments, perforation of tooth, root, sinus), medications, anesthetics and injections; discoloration of the face; reactions to medications causing drowsiness and lack of coordination; and antibiotics may inhibit the effectiveness of birth control pills.

Resorption*: the breakdown or destruction, and subsequent loss, of the structure of a tooth.

Ankylosis** (ang-kil-LO-sis): Condition in which the roots fuse directly to the jawbone. The fusion may occur because the ligament that normally surrounds the tooth in the jawbone is damaged.

Endodontics, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND RISKS OF TREATMENT I have received and read the Notice of Privacy Practices and Risks of Treatment of Endodontics, LLC.

{Please Print Name} _____ Relation to Patient _____

{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)

_____