PATIENT INFORMATION

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name ______________________ M.I. _____ Last Name ______________________________

Sex: ❑ Male ❑ Female Birth Date ___________________ Age __________ Soc. Sec. # ______________________________

Street ____ City _______________________ State ________ Zip __________

Home Tel. ______________ Cell. ___________________ Work __________________ Employer _______________________

Email ____________________________ Emergency Contact ________________________ Tel. _______________________

General Dentist ______________ Tel. _____________ If Greenberg, Aspen, Bright Now!, Sage, or Celebration, which location ____________

How did you hear about us? ❑ Insurance Co. ❑ Dentist ❑ Internet Search ❑ Online Yellow Pages ❑ Solar Bears/Predators ❑ Former Patient (their name: ______________) ❑ Friend/Family (their name: ______________) ❑ Other ___________

Who will be responsible for your account? ❑ Self (If self, skip to next section) ❑ Spouse ❑ Parent ❑ Other ________________

First Name ________________________ M.I. _____ Last Name ________________________ Soc. Sec. # ________________

Street ____ City _______________________ State ________ Zip __________

Home Tel. ______________ Cell. ___________________ Work __________________ Employer _______________________

DENTAL INSURANCE INFORMATION

Primary Insurance Company _________________________ Tel. __________________ ❑ DMO/HMO ❑ PPO ❑ DELTA CARE

Group # ___________________ Group Name _______________________ Subscriber ID # ___________________________

(If other than patient) Insured Party's First Name _________________ Last Name _____________________ Relation __________

Street ____ City _______________________ State ________ Zip __________

Birth Date ____________ Soc. Sec. # _________________ Tel. __________________ Employer _______________________

MEDICAL HISTORY **Have you had/you currently have:**

		Trauma to Your Mouth or Face	❑ Yes ❑ No	Bruxism/Teeth Grinding	❑ Yes ❑ No
Latex Allergy	❑ Yes ❑ No	HIV/AIDS	❑ Yes ❑ No	Cancer	❑ Yes ❑ No
Penicillin Allergy	❑ Yes ❑ No	Angina/Heart Attack	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Herpes Simplex I or II	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No
Fibromyalgia	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Venereal Disease	❑ Yes ❑ No
Diabetes or Hypoglycemia	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No	Asthma	❑ Yes ❑ No
Hepatitis/Liver Disease	❑ Yes ❑ No	Thyroid Disease	❑ Yes ❑ No	Sinus Problems	❑ Yes ❑ No
Irritable Bowel / Ulcerative Colitis	❑ Yes ❑ No	Bruising/Bleeding Problems	❑ Yes ❑ No	Spinal Surgery	❑ Yes ❑ No
Heart Murmur/Mitral Valve Prolapse	❑ Yes ❑ No	Stomach Ulcers	❑ Yes ❑ No	Substance Abuse	❑ Yes ❑ No
Rheumatic Fever	❑ Yes ❑ No	Organ Transplant	❑ Yes ❑ No	Mental Health Prob	❑ Yes ❑ No
Heart Valve/Joint Replacement	❑ Yes ❑ No	Tuberculosis/Lung Problem	❑ Yes ❑ No	Other Condition	❑ Yes ❑ No

Has your Physician/Cardiologist instructed you to premedicate with antibiotics prior to a dental appointment due to a medical condition such as Joint Replacement, MVP, or Rheumatic Fever? ❑ Yes ❑ No Are you currently Pregnant or Nursing? ❑ Yes ❑ No

If Yes to any, please explain: ____

Medications presently taking (bone density medications, bisphosphonates, blood thinners, vitamins/supplements, birth control, other):

____

Allergies to any medications and describe your reaction: ____

I certify that the above information is correct:

______________________________________ ____________________

Patient (or Legal Guardian) Signature **Date**

Acknowledgement of Receipt of Notice of Privacy Practices

Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), you have certain rights to privacy regarding your protected health information. You understand that this information can and will be used to:

- Conduct, plan and direct your treatment and follow-up among the health care providers or pharmacists who may be involved in that treatment directly or indirectly
- Obtain payment from third-party payers
- Conduct normal health care operations such as the business aspects of running the practice on a daily basis

By signing this you acknowledge you have received, read, and understand our Notice of Privacy Practices, which is posted in our lobby, containing a more complete description of the uses and disclosures of my protected health information. You understand we reserve the right to change our privacy practices as described in the Notice of Privacy Practices. 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: Office Manager

Telephone: 407-423-7667 Fax: 407-425-8629

Address: 610 N Mills Ave., Ste. 210, Orlando, Fl. 32803

Right to Restrict: You may request in writing that we restrict how your private information is used or disclosed to carry out treatment, payment, or health care options. You also understand we are not required to agree to your requested restrictions, but if we do agree then we are bound to abide by such restrictions.

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.

Signature: ______________________________ **Date:** ____________________

Print Name: ______________________________ **(specify if __ parent/guardian)**

FOR OFFICE USE ONLY

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

- ☐ Individual refused to sign acknowledgement
- ◇ Communications barriers prohibited obtaining the
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ◇ Other (Please Specify)

INFORMED CONSENT FOR ENDODONTIC TREATMENT

You have been referred to our specialty office because you may need to receive endodontic therapy. The need for this therapy is mostly due to trauma (often from a cavity, large restoration, or fracture) to your tooth, which has compromised the health of the pulp tissue. Endodontic (root canal) therapy is performed to relieve your current symptoms and save a tooth which might otherwise need to be removed. The therapy is accomplished by conventional endodontic therapy (removal of the nerve tissue and the sealing of the space that is created in the canal in order to relieve or prevent infection in the root of your tooth), or when needed, endodontic surgery. We do not do oral cancer screenings.

We would like our patients to be informed about the various procedures and risks involved in endodontic therapy/surgery versus other treatment choices. You will be required to sign this consent prior to your evaluation; **however, it does not commit to you opting for treatment**. It serves to acknowledge that you may ask any questions and have been informed and understand the following:

RISKS OF ANY DENTAL PROCEDURE: Included, but not limited to, are allergic reactions or complications from the methods and use of dental instruments, dental materials, medications, and injections. Complications may include swelling, bruising, sensitivity, bleeding, pain, itching, infection, tooth discoloration, restricted jaw opening, delayed healing, changes in the occlusion (biting), jaw pain or restricted opening, facial/neck muscle cramps and spasms, and numbness or tingling in the face and mouth. On infrequent occasions, development of an abscess, loosening of teeth, referred pain to the ear, neck or head, nausea, or sinus perforations may occur.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY AND SURGERY: Included, but limited to, are the possibility of broken instruments or debris within or surrounding the root, perforations (extra opening) of the crown or root of the tooth, damage to bridges, existing fillings, crowns, porcelain veneers, loss of tooth structure, cracked teeth, injury to soft tissues or nerves near the tooth, and small root fragments remaining. **If it is necessary to access the root through an existing crown, you may require a new crown.** Your general dentist will determine if a new crown is required. During the procedure, complications may become apparent which make treatment impossible, or which may require dental surgery or extraction (removal of the affected tooth). These complications include inability to access to the tooth needing treatment, blocked canals due to fillings or prior treatment, curved or narrow canals, natural calcifications, broken instruments, periodontal disease, resorptive defects, and fractures (cracks) of the teeth.

MEDICATIONS: Prescription medications may cause ineffectiveness of birth control pills, drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol or other drugs). It is not advisable to operate any vehicle or hazardous devices until you have recovered from their effects.

OTHER TREATMENT CHOICES: These include no treatment, waiting for more definite development of symptoms, or tooth extraction. All of these choices, and the choice not to complete the root canal treatment once it has begun, carry risks of their own including, but not limited to severe pain, infection and swelling, cyst formation, systemic disease, and loss of this tooth and possibly other teeth. Extraction frequently needs to be followed by a bridge, partial denture, or an implant to prevent shifting of the other teeth so that there will be an even distribution of the forces during chewing, and to keep a full appearance of the face. All these restorations are at an additional cost to the cost of extraction.

____________Patient (or Legal Guardian) Initials

INSURANCE: As a courtesy to you, we participate in many insurance plans, but our professional services are rendered and charged to you, not your insurance company. Your insurance policy is a contract between you/your employer/your insurance company, not our office. However, if insurance information is provided prior to your treatment and verification is obtained, we will accept assignment for the insurance portion of the benefits. Our office will not enter into a dispute with your insurance company over any claims, deductibles, co-payments, covered charges, "usual and customary" charges, etc., other than to supply factual information. All fees charged via attempts to collect any patient portion will be the financial responsibility of the patient or guardian. It is your responsibility to file any medical claims, workman's comp, secondary insurance, COBRA, or government/military insurance. Before services are performed, we collect payment of any deductible, co-payment, or other estimated amount not covered by your insurance company. **Any portion(s) of our services not covered by your insurance is your direct responsibility and payment for service is expected in full before services are rendered. Any payment options must be arranged and in writing prior to any treatment or service. Payment arrangements are available through Care Credit, upon credit approval. By signing below, I agree to be responsible for all charges for services and materials not paid by my dental benefit plan. I hereby authorize payment of the dental benefits otherwise payable to me directly to the named dental entity. Again, if insurance does not pay the contracted fee the patient will be responsible for the full payment amount.**

RETURNED CHECK FEE: There will be a $25 charge for all returned checks.

REFUND Policy: If patient is owed a refund, please allow 2 to 3 weeks for a refund to be processed and issued.

GENERAL INFORMATION: Although the endodontic therapy performed will be performed in a manner which will minimize and avoid risks and has a high degree of clinical success, it is still a biological procedure and cannot be guaranteed. Various factors that cannot be controlled contribute to the success of the therapy, which include, but are not limited to your general health, your healing capacity or resistance to infection, adequate gum attachment and bone support, the anatomy, condition and location of the roots, habitual clenching and grinding, the force with which you bite and a fracture of the treated tooth. If we detect a fracture in a tooth and still recommend treatment, be aware that despite treatment some cracks may continue to progress, ultimately resulting in loss of the tooth. However, treating the cracked tooth is still important because it will relieve pain and reduce the likelihood that the crack will worsen.

Rarely, a tooth that has had endodontic therapy may not relieve your pain and symptoms totally, and may require retreatment, surgery, even extraction, or treatment of another tooth. There will be a full charge for all completed cases, regardless of success or failure. If a treatment cannot be completed due to a complication, there will be a charge for all procedures performed up to that point.

It is your responsibility to seek attention should any undue circumstances occur postoperatively and diligently follow any preoperative and postoperative instructions given to you. **UPON COMPLETION OF THE ENDODONTIC PROCEDURE, YOU MUST IMMEDIATELY (in no case longer than 30 days) RETURN TO YOUR GENERAL DENTIST FOR PERMANENT RESTORATION OF THE TOOTH, (the cost of which is not included in our fee). Failure to do so could contaminate the root canal and cause the need for retreatment or extraction. Dr. Temple's office will not be responsible if postoperative instructions are not closely followed.**

EXTRACTION REFUND POLICY: If an endodontically treated tooth (which was considered to have a good long-term prognosis at the time of completion of treatment) is found to have developed a fracture after the root canal and requires the tooth to be extracted, the patient may be entitled to a 50% refund of their payment within 30 days of the initial treatment. Refunds will require a re-evaluation by our practice during the 30-day period following initial treatment and an approval of extraction by Dr. Temple. After 31 days following the initial treatment, the patient may be entitled to a 25% refund of their payment for treatment. If after 90 days the tooth must be extracted, a refund will not be issued, as treatment had been completed in good faith, and the patient had fully informed consent at the time of the initial treatment. This refund does not entitle the patient to a refund of any approved and issued insurance payment(s) toward the treatment –only what the patient paid at the time of treatment. A receipt of extraction is required in order to approve any refund. The extraction refund will be qualified based on time of service.

____________Patient (or Legal Guardian) Initials

BISPHOSPHONATES

BISPHOSPHONATES: Bisphosphonates are a class of medication that are used in the medical management of several disease states characterized by bone loss or fragility. Most commonly, they are used in the treatment of osteoporosis, multiple myeloma, and metastatic carcinoma. A list of Bisphosphonates includes, but is not limited to: Fosamax, Actonel, Aredia, Zometa, Boniva.

_____ YES, I am currently taking or have previously taken a form of Bisphosphonate.

_____ NO, I have never taken a form of Bisphosphonate.

I have read, acknowledge, and understand the content of this document. I consent to allow and authorize the dentist and/or his staff to perform any examinations, diagnostic procedures, and render any treatment or medications necessary or advisable to my dental condition as it stands now or as it arises during treatment.

____

Patient (or Legal Guardian) Printed Name

____

Patient (or Legal Guardian) Signature Date

 Rev 4/2022

Protected Health Information (PHI) Disclosed

Last Name (Patient) ______________________________

First Name (Patient) ________________________ **MI**___

Last 4 Digits of Social Security #_______________ Date of Birth ______/______/___________

PHI Disclosed

We cannot discuss your Protected Health Information (PHI) with anyone other than yourself, unless you authorize us to do so. Please list below the name(s) of the individual(s) you authorize our office to discuss your care with; as well as, to release any medical history or any prescribed medications you may NOT be able to pick up to the individual(s) listed below. Your Protected Health Information (PHI) will be disclosed to the individual(s) listed below unless you notify us otherwise in writing.

____ ____

____ ____

____ ____

Please specify anything you do NOT want to be released to those listed above:
(i.e. X-rays, Doctor's notes, etc.)

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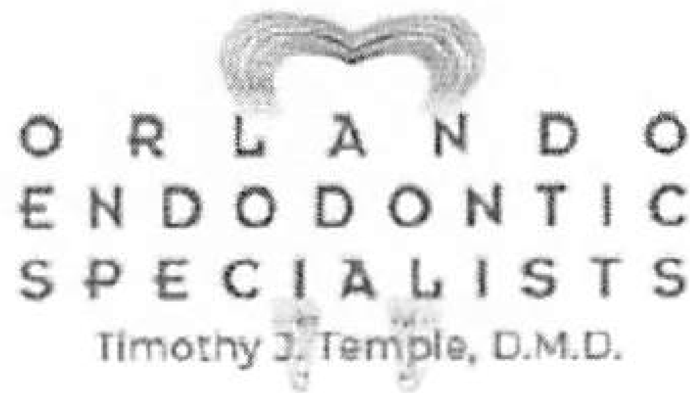
____ ______________

Patient (or Legal Guardian) Signature Date



Appointment Cancellation Policy

We strive to render excellent endodontic care to you and the rest of our patients. To be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

If you are unable to keep your appointment, kindly give our office a minimum of **24-hours**' notice, which allows other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within **24-hours**, we reserve the right to charge a fee of $135.00. This fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Additionally, if a patient is more than 15 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $135.00 cancellation fee may be charged.

It is the responsibility of the patient to inform our office of any changes in address or contact numbers.

We provide an appointment reminder call or text as a courtesy extended by our office to the patient and this in no way cancels this policy

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

____
Patient (or Legal Guardian) Printed Name

____
Patient (or Legal Guardian) Signature Date

NOTIFICATION OF POST TREATMENT PROCEDURE

Patient has been informed and is aware that any treatment accessing through a permanent crown, or a permanent bridge has a **HIGH** possibility that a new permanent crown or permanent bridge will be needed. Final restoration is to be completed by a General Dentist.

Patient must return to their General Dentist to have the final restoration done within 30 days from the date of treatment. If the patient does not receive the final restoration within 30 days from the date of treatment, the treatment may be compromised and/or contaminated and the patient will need to have a re-treatment performed on the same tooth. Patient will be responsible for any amount due on services performed.

____

Patient (or Legal Guardian) Printed Name

____

Patient (or Legal Guardian) Signature Date

CBCT (Cone Beamed Computed Tomography) SCAN

What is a CBCT scan?

In less than a minute, about 150-200 images are captured from a variety of angles. This data is used to reconstruct a 3D image of your teeth, mouth, and jaw. A CBCT scan uses ***less*** radiation and now is a ***standard of care in the practice of endodontics***. This results in a much more detailed and effective view of your dental health; for example, the CBCT scan will show any extra canals on the tooth, fracture, infections, or resorption, that are not seen on the 1-dimensional picture of a radiograph. The CBCT scan will also show any additional teeth that may need work done, and the scan will be good for 1 year. A copy of the CBCT scan will also be provided to you for your own personal records.

I, ____ agree to have the

(Printed Name)

CBCT scan. ***I understand that my insurance does not cover this procedure; the cost is $375 and non-refundable***.

____//____________________

(Signature) (Date)

Declining the scan

I, ____ am

(Printed Name)

relinquishing any responsibilities for a misdiagnosis that includes, but is not limited to extra canals on the tooth, fracture, infections that are not seen on the 1-dimensional picture of a radiograph, resorption, etc., that end with the tooth being extracted as well. **By signing this document, you understand that Dr. Timothy Temple is not responsible for any misdiagnosis or extraction of the tooth.**

____//_______________________

(Signature) (Date)