Welcome to Our Office!

Date:_____

PATIENT INFORMATION:

_____ _____ _____ _____
Last Name First Name M I Name Preference

Address:_____City:_____State:_____Zip:_____

Home #:_____Work #:_____Cell #:_____Email:_____

Social Security #:_____-_____-_____Date of Birth: _____Sex: ☐M ☐F

Your Employer: _____ Employer's Address:_____

General Dentist:_____Physician:_____ Referred By:_____

Emergency contact Name: _____Work #:_____Home #:_____

MEDICAL HISTORY: Please check Yes/No for any of the following which may apply to you now /in the past:

Y	N		Y	N		Y	N		Y	N	
☐	☐	Artificial Heart Valve	☐	☐	Tuberculosis	☐	☐	Heart Murmur	☐	☐	Angina Pectoris
☐	☐	Rheumatic Fever	☐	☐	Hepatitis A, B or C	☐	☐	Heart Surgery	☐	☐	Artificial Joint
☐	☐	Mitral Valve Prolapse	☐	☐	HIV Positive	☐	☐	Heart Pacemaker	☐	☐	Drug Addiction
☐	☐	Lesions	☐	☐	Heart Disease/Attack	☐	☐	Diabetes	☐	☐	Pain in Jaw Joints
☐	☐	Asthma	☐	☐	High Blood Pressure	☐	☐	Thyroid Disease	☐	☐	Bleeding Disorders
☐	☐	Tobacco Use	☐	☐	Cancer	☐	☐	Liver/Kidney Disease	☐	☐	Epilepsy or Seizure

Have you ever taken Bisphosphonates?____(i.e. Fosamax, Aredia, Zometa, Actonel, Boniva, Skelid, Didronel, Bonefos Ostec)

Any other serious illness/operation not listed above?_____

Do you require Premedication for your dental appointments? ☐Yes ☐ No; If yes, list reason:_____

Have you ever had an unusual reaction to latex, local anesthetics, or drugs such as Penicillin, Clindamycin, Codeine, Aspirin, Sulfa, or any other medication? If yes, Please explain:_____

What Medication(s) are you presently taking?_____

Have you taken Aspirin or Ibuprofen in the last 72 hours? ☐Yes ☐No; If yes: ☐ Aspirin ☐Ibuprofen; How many?_____

Women: Are you pregnant? ☐ Yes ☐No; If yes, what month?_____

THE PURPOSE of endodontic treatment or root canal treatment is to save the tooth rather than remove it. Although treatment has a high degree of success, it can not be guaranteed. Occasionally, a tooth that has had a root canal treatment may require re-treatment, surgery or even extraction.

Treatment is usually a non-surgical procedure, but in some cases, a surgical approach is necessary. Before any treatment is begun the reason(s) will be explained, including alternative modes of therapy. Occasionally, pre-medication may be indicated. This will be discussed in advance.

PLEASE NOTE: The fee will not include a permanent filling or crown on the tooth. You must return to your general dentist to have that treatment completed.

I consent to necessary treatment and authorize the release of any information needed for continued treatment.

X_____ _____
SIGNATURE OF PATIENT (CUSTODIAL PARENT/GUARDIAN OF MINOR) DATE

PRIMARY DENTAL INSURANCE:

Name of Insured Person: _____

Employer/Retired From: _____

Name of Insurance Company: _____

SECONDARY DENTAL INSURANCE:

Name of Insured Person: _____

Employer/Retired From: _____

Name of Insurance Company: _____

I hereby authorize the provider to file my insurance and benefits to be paid directly to the provider. I also understand that when my particular insurance is filed:

1. I authorize the release of any information related to my claim to my insurance company.

2. I am ultimately responsible for the balance on my account for any professional services rendered regardless of the amount my insurance pays toward my account. We ask that patients with insurance pay estimated portion of the cost of treatment; at the time service is received.

3. Any balance not paid by my insurance will be due within two weeks of the statement date, a **FINANCE CHARGE** may be added to the account. The **FINANCE CHARGE** will be a periodic rate **1.5%** per month, which is an **ANNUAL PERCENTAGE RATE** of **18%,** applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection on this account.

If patient is under the age of 18 years old, please complete the following:

Responsible Party: _____ Relationship to Patient: _____

Date of Birth: _____ Social Security #: _____

Address:_____City:_____State:_____Zip:_____

Home #:_____Work #:_____

I ☐HAVE ☐DO NOT HAVE dental insurance. I am financially responsible for fees incurred at the time of service.

X_____ _____

SIGNATURE OF PATIENT (CUSTODIAL PARENT/GUARDIAN OF MINOR) DATE

Grand River
ENDODONTICS PC
Dr. Sarah Lennan Masterson D.D.S., M.S.D.
4211 Parkway Place SW, Suite 104
Grandville, MI 49418
(616)-249-3500

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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 of 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 our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at any time by contacting a staff member of our office.

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 any staff member of our office. Please understand that revocation of the 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:
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 a representative on behalf of the patient signs this Consent form, complete the following:

Personal Representative's Name:_____Relationship to Patient:_____

INFORMED CONSENT

I, the undersigned, affirm all information provided is accurate. I understand that treatment is no guarantee of success, and that factors such as infection, pain, tooth fracture, and other complications (i.e. separation of an instrument within the root, root perforation) may affect the outcome of treatment. I understand that any fees incurred, even if covered with dental insurance, are the responsibility of the patient/guardian. Any questions will be answered and I have the right to deny treatment.

I ALSO UNDERSTAND THAT I AM TO RETURN TO MY DENTIST FOR A PERMANENT RESTORATION OF THE TREATED TOOTH WITHIN 30 DAYS.

My signature signifies that I have read and understand the above information.

PATIENT_____ _____
Signature Date

(If patient is a minor: Parent signature required)

Dr. Sarah Lennan Masterson D.D.S., M.S.D.

Questions We Ask About Your Toothache…

Name: _____

1. How would you rate your pain level today?

No Pain Very Painful

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐

2. Do you know which tooth is hurting you today?
3. How long has it been hurting?
4. Is the tooth sensitive to **bite** on?
5. Is the tooth sensitive to **cold**?
6. Is the tooth sensitive to **heat**?
7. Does the tooth ever start **aching on its own**?
8. Have you had any **swelling** in the gum area around the tooth?
9. Has there been any recent work done on the tooth (filling, crown, etc)?
10. Are you currently taking any **antibiotic or pain killer** for this tooth?
11. Have you ever had a root canal?
12. Has this tooth had a previous root canal? ☐Yes ☐No ☐Not Sure If yes, how long ago?
13. Do you experience anxiety when going to the dentist?

Comments_____

_____

_____