

**PATIENT INFORMATION**

Date: \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT. \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SEX: M F (PLEASE CIRCLE)

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

**EMPLOYMENT INFORMATION**

EMPLOYER'S NAME: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_

**FOR PATIENTS WITH DENTAL INSURANCE** (Please provide insurance card or fill out below)

INSURANCE COMPANY: \_\_\_\_\_

PHONE NUMBER & ADDRESS: \_\_\_\_\_

POLICY HOLDER'S ID# \_\_\_\_\_

IS PATIENT THE POLICY HOLDER? Y N (PLEASE CIRCLE)

*IF ANSWERED NO, PLEASE FILL OUT BELOW*

POLICY HOLDER'S NAME \_\_\_\_\_

RELATIONSHIP TO POLICY HOLDER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

**Endodontic Informed Consent**

I understand the goal of endodontic root canal treatment or evaluation is to retain a tooth that may otherwise require extraction. Although endodontic root canal treatment usually has a high degree of clinical success, it is a dental-biological procedure, whose results cannot be guaranteed. During the procedure the possibility of separated instruments, undetected root canals, or perforation of the tooth may occur. This may have an impact on the prognosis of the root canal procedure. Occasionally, endodontic root canal treatment may fail, resulting in tooth loss. A permanent (outside) restoration, such as a crown or onlay, will be placed afterwards by my restorative dentist. I agree to notify my restorative dentist immediately following completion of the root canal treatment so that a restoration may be placed over my root canal-filled tooth. Following completion of endodontic root canal treatment, fracture and loss of my root canal-filled tooth due to brittleness may be more likely to occur unless my root canal-filled tooth is restored within a month following completion of endodontics.

Signature of Patient or Parent Witness: \_\_\_\_\_

Witness: \_\_\_\_\_

(PLEASE SEE NEXT PAGE)

# Practice Limited to Endodontics

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Rory E. Mortman, D.D.S.  
Jeffrey S. Albert, D.M.D.  
Kristen Bingham, D.M.D., M.S.  
Sandra Ghattas, D.M.D., M.S.

***PLEASE READ THE BELOW PARAGRAPH CAREFULLY  
AS IT PERTAINS TO PAYMENT AND INSURANCE ISSUES***

## **Patient Financial Responsibility Policy**

All patients are responsible for the payment in full of all services rendered on their behalf.

If this account needs to be placed for collection due to delinquency - you will be responsible for any collection and/or attorney fees.

I acknowledge full responsibility for the payment of such services for my root canal treatment and agree to pay for them, in full, AT or BEFORE COMPLETION.

Signed: Patient or Parent: \_\_\_\_\_ Date: \_\_\_\_\_

## **For patients with dental insurance...**

I authorize my insurance carrier to pay any dental benefits of my plan directly to this dental office. I also authorize the release of any information necessary to process my dental insurance claim.

We will file insurance as a courtesy to our patients. Insurance companies compensate according to their fee schedule, therefore it is necessary that the patient pay their co-pay at the time of the service. If your insurance company pays more than your outstanding balance, we will send you a refund. You remain responsible for deductible and payment of non-covered services. Your insurance policy is a contract between you and your carrier. If the insurance company rejects your claim in full or in part, you are responsible for paying for the services rendered.

We will allow 45 days for payment from the insurance company. After that, we will bill you, the patient, for the complete balance of the account.

Signed: Patient or Parent: \_\_\_\_\_ Date: \_\_\_\_\_

# **MEDICAL HISTORY FORM**

Patient Name: \_\_\_\_\_

**For the following questions, circle YES or NO, whichever applies. Your answers are for our records only and will be considered confidential.**

Are you in good health?      YES      NO      Date of last physical exam: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Has there been any change in your general health within the past year?      YES      NO

Are you now under the care of a physician?      YES      NO

If so, what is the condition being treated? \_\_\_\_\_

The name and address of my physician is \_\_\_\_\_

Have you had any serious illness, operation, or been hospitalized in the past 5 years?      YES      NO

If so, what was the illness or problem \_\_\_\_\_

Are you taking an medicine(s) including non-prescription medicine?      YES      NO

If so, what medicine(s) are you taking? \_\_\_\_\_

## **Do you have or have you had any of the following diseases or problems?**

Damaged heart valves	YES	NO	Artificial heart valves	YES	NO
Heart murmur	YES	NO	Rheumatic heart disease	YES	NO
Cardiovascular disease	YES	NO	Heart Trouble	YES	NO
Heart attack	YES	NO	Angina	YES	NO
Coronary Insufficiency	YES	NO	Coronary occlusion	YES	NO
High blood pressure	YES	NO	Arteriosclerosis	YES	NO
Stroke	YES	NO	Swollen Ankles	YES	NO

Do you have chest pain upon exertion?      YES      NO

Are you ever short of breath after mild exercise or when lying down?      YES      NO

Do you have inborn heart defects?      YES      NO

Do you have a cardiac pacemaker?      YES      NO

Allergies	YES	NO	Sinus trouble	YES	NO
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Asthma	YES	NO	Hay fever	YES	NO
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Fainting spells	YES	NO	Seizures	YES	NO
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Persistent diarrhea	YES	NO	Recent weight loss	YES	NO
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Diabetes	YES	NO	Hepatitis	YES	NO
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Jaundice	YES	NO	Liver disease	YES	NO
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AIDS	YES	NO	HIV infection	YES	NO
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Thyroid problems	YES	NO	Respiratory problems	YES	NO
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Emphysema	YES	NO	Bronchitis	YES	NO
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Arthritis	YES	NO	Stomach ulcers	YES	NO
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**(PLEASE SEE NEXT PAGE)**

Kidney trouble	YES	NO	Tuberculosis	YES	NO
Persistent cough	YES	NO	Bloody cough	YES	NO
Low Blood pressure	YES	NO	Epilepsy	YES	NO
Neurological disease	YES	NO	Cancer	YES	NO
Persistent swollen glands in the neck	YES	NO	Osteoporosis	YES	NO
Sexually transmitted disease	YES	NO			
Problems with mental health	YES	NO	Do you take Bisphosphonate Drugs?		
Problems of the immune system	YES	NO		YES	NO
Have you had abnormal bleeding?	YES	NO			
Have you ever required a blood transfusion?		YES	NO		
Do you have any blood disorder such as anemia?		YES	NO		
Have you had any treatment for a tumor or growth?		YES	NO		

**Are you allergic or have had a reaction to:**

Local anesthetics	YES	NO	Novocaine	YES	NO
Penicillin	YES	NO	other antibiotics	YES	NO
Sulfa drugs	YES	NO	Barbiturates	YES	NO
Sedatives	YES	NO	Sleeping pills	YES	NO
Aspirin	YES	NO	Iodine	YES	NO
Codeine	YES	NO	Other narcotics	YES	NO

Other \_\_\_\_\_

Have you had any serious trouble associated with any previous dental treatment? YES NO

If so, please explain \_\_\_\_\_

Do you have any disease, condition or problem not listed above that you think I should know about? YES NO

If so, please explain \_\_\_\_\_

**WOMEN**

Are you pregnant? YES NO

Are you nursing? YES NO

Do you have any problems associated with your menstrual period? YES NO

Are you taking birth control pills? YES NO

**CHIEF DENTAL COMPLAINT**

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiry set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_  
Signature of Patient or Parent

# TELL US ABOUT YOUR DENTAL SYMPTOMS

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

1. Are you experiencing any pain at this time? If not, please go to Question 5. Yes \_\_\_ No \_\_\_
2. If yes, can you locate the pain? Yes \_\_\_ No \_\_\_
3. When did you first notice the symptoms? \_\_\_\_\_
4. Did symptoms occur suddenly or gradually? \_\_\_\_\_

Please check the frequency and quality of the discomfort, and the number that most closely reflects the intensity of your pain:

## LEVEL OF INTENSITY

## FREQUENCY

## QUALITY

(On a scale of 1 to 10)

1 = Mild, 10 = Severe

1\_\_ 2\_\_ 3\_\_ 4\_\_ 5\_\_ 6\_\_ 7\_\_ 8\_\_ 9\_\_ 10\_\_

\_\_\_ Constant

\_\_\_ Sharp

\_\_\_ Intermittent

\_\_\_ Dull

\_\_\_ Momentary

\_\_\_ Throbbing

\_\_\_ Occasional

Is there anything you can do to relieve the pain?

Yes \_\_\_ No \_\_\_

If yes, what? \_\_\_\_\_

When eating or drinking, is your tooth sensitive to:

Heat \_\_\_ Cold \_\_\_ Sweets \_\_\_

Does your tooth hurt when you bite down or chew?

Yes \_\_\_ No \_\_\_

Does it hurt when you press the gum tissue around this tooth?

Yes \_\_\_ No \_\_\_

Does a change in posture (lying down or bending over) cause your tooth to hurt?

Yes \_\_\_ No \_\_\_

5. Do you grind or clench your teeth?

Yes \_\_\_ No \_\_\_

6. If so, do you wear a night guard?

Yes \_\_\_ No \_\_\_

7. Has a restoration (filling or crown) been placed on this tooth recently?

Yes \_\_\_ No \_\_\_

8. Prior to this appointment, has root canal therapy been started on this tooth?

Yes \_\_\_ No \_\_\_

9. Any past trauma or injury to this tooth?

Yes \_\_\_ No \_\_\_

10. If the answer to the preceding question is yes, describe past trauma and state the occurrence date.

11. Is there anything else we should know about your teeth, gums, or sinuses that would assist us in our diagnosis? \_\_\_\_\_

Signature of Patient (or Parent) \_\_\_\_\_ Date \_\_\_\_\_

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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

“You May Refuse to Sign This Acknowledgement”

I, \_\_\_\_\_ have received a copy of this office’s Notice of  
Privacy Practice.

Please Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

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### For Office Use Only

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

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

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## **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.**

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### **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 the 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 12/01/02, 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.

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### **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 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 qualification 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 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 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 experience with common practice to make reasonable inferences of your best interest 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 and 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).

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#### **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 \$0.50 for each page, \$\_\_ 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.

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#### **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 Services. We will provide you with the address to file your complaint with the U.S. Department of Health 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.

1501 Presidential Way, Suite 7

West Palm Beach, FL 33401

Telephone: 561/684-1312

Fax: 561/684-0182