RCS
Root Canal Specialists

130 New London Tpke., Suite 4
Norwich, CT 06360
P. 860-889-1660
F. 860-889-9714

rootcanalspec@cs.com
www.endodonticsct.com

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 Practices.

_____
Please Print Name

_____
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)

_____

_____

_____

PATTERSON# 200064839

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PERSONAL INFORMATION

Today's Date _____

(Mr. / Mrs. / Ms. / Dr.) Name _____ Nickname _____

Address _____ City _____ ST _____ Zip _____

Home Phone _____ Cell Phone _____ Soc Sec # _____

Birth Date _____ Sex _____ Single ___ Married ___ Divorced ___ Widowed ___ Separated ___

Employer _____ Occupation _____

Address _____ City _____ ST _____ Zip _____

Work Phone _____ Ext _____ How long employed there _____

In the event of an emergency, who should we contact?
Name _____ Relationship _____ Phone _____

Who referred you to our office? _____

HEALTH HISTORY

Your overall health or medications that you may be taking could have an important impact on the dental care you will be receiving. Thank you for answering the following questions.

Physician's Name _____ City/Town _____ Phone _____

Have you ever had any of the following? (Check boxes that apply)

____ Heart Problem
____ Artificial Heart Valves
____ Rheumatic Fever
____ High Blood Pressure
____ Low Blood Pressure
____ Circulatory Problems
____ Artificial Joints
____ Blood Diseases
____ Hemophilia
____ Recent Weight Loss
____ Cancer (area: _____)
____ Radiation Treatment
____ Chronic Diarrhea

____ Asthma
____ Respiratory Disease
____ Diabetes
____ Special Diet
____ Epilepsy
____ Migraines/Headaches
____ Liver Disease
____ Hepatitis/Jaundice
____ Psychiatric Care
____ Nervous Problems
____ Thyroid Problem
____ Swollen Neck Glands
____ Arthritis

____ Latex Allergies
____ Allergies/Sinus Problem
____ Allergies to Medicines
____ Allergies to Anesthetics
____ Are you taking Aspirin?
____ "AIDS" or other Immunosuppressive Disorder
____ Stroke
____ Ulcer
____ Venereal Disease
____ Chemical Dependency
____ Currently Pregnant
____ Nursing Mother

Please list any medications you are currently taking: _____
_____

Do you have any drug allergies or have you ever had an adverse reaction to medication:
If so, please describe them _____
Have you ever responded adversely to medical or dental treatment? _____
Are you under the care of a physician? If yes, what condition? _____
Is there any other medical condition we should know about? _____

Interviewing Dr.'s Signature _____ Date: _____

PLEASE CONTINUE INFORMATION ON BACK OF THIS PAGE .....

FINANCIAL POLICY INFORMATION

Patients without Insurance Assistance: **Payment in full is due at the time of your appointment.** Your payment can be made by cash, personal check or credit card. Please see the receptionist for details or questions.

Patients with Insurance Assistance: Your insurance may not cover all of your treatment; therefore we require your "estimated" co-payment at the time of your appointment. In order to utilize your insurance in our office, we will need to verify your coverage prior to any treatment. **We cannot guarantee the amount paid by your insurance.** As a courtesy to you, our patient, we will submit to your insurance company for you. We may not be a direct provider for your insurance company. Please understand that your insurance policy is a contract between you and your insurance company. **The payment for your treatment is your responsibility.**

I have read and understand the financial information: _____ **Date**
(Signature of responsible party, patient or guardian)

INSURANCE INFORMATION:

Primary Dental Insurance

Name of Insured _____

Insured's birth date _____

Insured's Soc Sec # _____

Insured's Employer _____

Insured's Occupation _____

Relationship to patient _____

Insurance Company _____

Insurance Co. Address _____

_____

Group # _____

Subscriber or ID # _____

Secondary Dental Insurance

Name of Insured _____

Insured's birth date _____

Insured's Soc Sec # _____

Insured's Employer _____

Insured's Occupation _____

Relationship to patient _____

Insurance Company _____

Insurance Co. Address _____

_____

Group # _____

Subscriber or ID # _____

Authorization and Release

I authorize **Root Canal Specialists, P.C.** to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my dependent to third party payers and /or other health practitioners. I authorize and request my insurance company to pay directly to **Root Canal Specialists, P.C.,** any insurance benefits otherwise payable to me. I understand that my dental insurance may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature _____ **Date** _____
(Signature of responsible party, patient or guardian)

The questions on this form have been accurately answered to the best of my knowledge. The information obtained will be utilized in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold my dentist or any other member of his/her staff responsible for any errors and/or omissions that I may have made in completing this form.

Signature _____ **Date** _____
(Signature of responsible party, patient or guardian)

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Pre-Treatment Root Canal Instructions

1. You have been referred to our office for root canal treatment because your general dentist knows that we have expertise in root canal treatment, which allows us to handle your care in an efficient and predictable manner. This minimizes pain and discomfort for you and maximizes a successful outcome. Your care in our office is a trust we do not take lightly. Hopefully, you will notice that the most up to date infection control protocols and advanced dental equipment is used to treat you. Please see our brochures about root canal treatment published by the American Association of Endodontists located in our reception area.

2. We are concerned about any medical problems which may complicate treatment so please discuss these concerns with the doctor.

3. The benefit of the root canal procedure is to treat your diseased oral tissues. Left untreated, your condition may worsen and result in swelling, pain and infection which could make you physically ill. Eventually you could lose the involved tooth. Alternate methods of treatment other than the root canal treatment would include extraction or no treatment at all.

4. Several x-ray films will be needed to be taken during the treatment. The total number is usually between 3 to 6 individual films. We use digital x-rays and a lead apron to protect you from scatter radiation. Any residual radiation exposure is quite minimal. However, if you suspect that you are pregnant, or have concerns about the x-rays, please discuss them with the doctor.

5. Root canal treatment usually requires one or two appointments which are approximately one to one and half hours in length. Occasionally your treatment will require additional visits or lengthier appointments.

6. Our office does not always place the permanent filling in your tooth. After your root canal treatment is completed, you will be informed if the filling we placed is temporary or permanent. If a **temporary** filling is placed, it is **your responsibility to go back to your general dentist to have the permanent restoration done.**

7. We have a very high success rate for root canal treatment in our office. However, success cannot be guaranteed, since every tooth is different and every individual unique. Occasionally, routine root canal therapy is not adequate to solve your dental problem and additional treatment or surgery may be needed to correct the problem.

8. Although unlikely, the treatment subjects you to certain risks including but not limited to the following: post operative discomfort and infection which may require additional treatment, weakening of the tooth and possible loss of the tooth despite our best efforts. We do every thing possible to minimize risks and we have saved many teeth through root canal treatment!

Please be aware that your scheduled treatment appointment is important to you and to us. If you fail to show up for your scheduled appointment or cancel with less than 24 hour notice we may be forced to terminate our doctor patient relationship with you. Please don't let this happen.

Please sign that you have read this information: _____ Date: _____

ROOT CANAL SPECIALISTS, PC
130 NEW LONDON TPKE.
NORWICH CT 06360

NON SURGICAL ENDODONTIC CONSENT FORM

Endodontic treatment has been recommended as a procedure for your tooth in an attempt to prevent the tooth's premature loss. My alternative to the proposed treatment is to have no treatment done or to have the tooth extracted. If no treatment is done, there is the risk of infection, pain and/or loss of the tooth. If the tooth is extracted, then some form of an artificial replacement tooth may be constructed.

WHAT ARE THE POSSIBLE COMPLICATIONS?

Risks or complications are rare, but some may still occur. The doctor has explained to me that there are certain inherent and potential risks in any treatment plan or procedure. I understand that the following may be inherent or potential risks for the treatment:

Swelling, 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; jaw muscle cramps and spasms; temporomandibular joint difficulty; loosening of teeth, crown or bridges; delayed healing, sinus perforations, treatment failure, complications resulting from the use of dental instruments(broken instruments, perforation of tooth, root, sinus), medications, anesthetics, and injections; extruded gutta percha and/or sealer, root perforations, ingestion of sodium hypochlorite or extrusion of sodium hypochlorite, fracture of porcelain crowns, discoloration of teeth, reactions of medications, and antibiotics may inhibit the effectiveness of birth control pills.

Endodontic treatment is a highly successful procedure for postponing the loss of teeth that would otherwise be extracted. Unfortunately, not all teeth will respond favorably to the treatment. Consequently, it is possible that in the future, my tooth may require additional treatment such as another endodontic procedure, surgery, or even extraction.

As for all dental procedures, I understand it is not possible to guarantee the success of the endodontic procedure, despite all of the efforts of the doctors.

Medications may be given for pain or infection. If given pain medication, I should not drive an automobile nor operate equipment that may be hazardous to others or myself. If I am a female who is taking birth control pills, it is possible that 1 could become pregnant while taking an antibiotic. Consequently, an alternative form of contraception may be necessary while taking the antibiotic.

IMPORTANT:

After completion of the root canal therapy, unless otherwise indicated, it is YOUR responsibility to see your restorative dentist for final restoration or crown of the involved teeth, which is to protect your tooth from decaying or fracturing. Failure to see your restorative dentist after completing your treatment may result in the failure of the root canal and/or loss of the tooth.

CONSENT FOR ENDODONTIC TREATMENT:

I have read the above and I understand that no treatment is without some measure of risk; and the risks of the proposed treatment have been explained to me. I prefer to undergo the ENDODONTIC (root canal) procedure in order to attempt to postpone the loss of my tooth. I hereby authorize the doctors and their assistants to perform the necessary endodontic procedures which have been described to me. I further request and authorize them to do whatever they deem advisable and necessary as a result of unforeseen circumstances. It has been explained to me and I understand that a perfect result cannot be guaranteed or warranted. I have been given the opportunity to question the doctor concerning the nature of treatment, the inherent risks of the treatment, and the alternatives to this treatment.

I, the undersigned, consent to the performing of any dental procedures of the tooth which may be necessary or advisable in the opinion of my doctor. I also understand my other options are extraction or no treatment at all. I understand that only the root canal is to be done at this office.

Printed Name_____ **Signature**_____ **Date**_____

Witness_____ **Tooth/Teeth**_____

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 REVIEW IT 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 of 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 presenting 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 from us upon request.

ITEM 070-6028/25944 © MAY 2002

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 _____, 20___ 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 if 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

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