Commonwealth Endodontics
WE SAVE TEETH.

www.cwendo.com
Tel: 804-501-0501

PATIENT INFORMATION

Date: _____ Referred by: _____ General Dentist: _____ Tooth #: _____

Patient _____ _____ _____ _____
LAST FIRST Nickname MI

DOB _____ SSN _____ □ MALE □ FEMALE □ CHILD*

Street Address _____ □ SINGLE □ MARRIED □ DIVORCED □ WIDOWED
City _____ State _____ Zip Code _____
Primary Phone _____
Secondary Phone _____ *Parent/Guardian Name if patient is under 18:
Email Address _____ _____
Employer _____

In case of an emergency, please provide information for the nearest relative or designated contact person:

_____ _____ _____
Name Relationship Phone #

MEDICAL HISTORY

Primary Care Physician _____ Phone _____
Have you had any operations? □ YES □ NO If yes, please describe: _____

Prescription/Over-the-Counter Medications currently taking: _____

Do you have a latex allergy? □ YES □ NO
Have you had an allergic or adverse reaction to: Anesthetic? □ YES □ NO Local dental anesthetic? □ YES □ NO General/IV? □ YES □ NO
Do you have any drug allergies? □ **YES** □ **NO** If yes, please explain _____

Are you taking or have taken any bisphosphonate drugs? (Ex: Boniva, Fosamax) □ YES □ NO
Are you taking or have taken blood thinner? (Coumadin, Platelet Inhibitors, or Aspirin Therapy) □ YES □ NO
If yes, reason why? _____

Medical History – Please check all that apply

□ Anemia
□ Arthritis, Rheumatism
□ Artificial Heart Valve
□ Artificial Joints
□ Asthma
□ Back Problems
□ Bleeding Disorder
□ Cancer
□ Chemical Dependency
□ Chemotherapy
□ Circulatory Problems
□ Cortisone Treatment
□ Diabetes
□ Epilepsy
□ Fainting
□ Glaucoma
□ Headaches or Migraines
□ Heart Murmur
□ Heart Problems
□ Hemophilia
□ Hepatitis
□ High Blood Pressure
□ HIV/AIDS
□ Jaw Pain or TMJ
□ Kidney Disease
□ Mitral Valve Prolapse
□ Pacemaker
□ Radiation Therapy
□ Respiratory Disease
□ Rheumatic Fever
□ Shortness of Breath
□ Sleep Apnea
□ Stroke
□ Thyroid Problems
□ Tuberculosis
□ Ulcer
□ Other _____

For Women

Are you pregnant? □ YES □ NO
If yes, how many months? _____
Are you nursing? □ YES □ NO
Do you suspect you are pregnant? □ YES □ NO
Are you taking birth control pills? □ YES □ NO

CWE Reviewed Medical Hx: _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of his staff at Commonwealth Endodontics responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature of patient or legal designate Date

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ENDODONTIC CONSENT & INFORMATION FORM

Endodontics (root canal therapy or treatment) is the cleaning, shaping, disinfecting, and filling of the root canal(s) of the diseased tooth. The canal is the space inside of the root of the tooth. The tissue inside of the canal is a remnant of the tooth's development. A tooth has live cells on the outside of the root. The body continues to recognize the tooth as being alive after endodontic therapy has been completed. Treatment may require more than one visit to complete. Please be advised of the following:

1. Root canal therapy is 90% -95% successful. Retreatment is 80%-85% successful. Endodontics medicine and dentistry are not an exact science. No guarantee of treatment success can be given or implied. Other endodontic therapies or extraction may become necessary if post-treatment disease develops.
2. Endodontic treatment started or completed in other offices may have different outcomes than expected under optimal conditions.
3. Proper restoration after endodontic therapy is required. Please contact your dentist soon after the completion of your care at our office to schedule your restoration. Your restorative dentist will place either a filling or a crown on your tooth. The filling that we placed for you is only temporary.
4. Possible complications as a result of electing endodontic therapy include (a) procedural, (b) swelling soreness, infection, trismus (limiting opening), or discoloration of the soft or hard tissues, (c) fracture of tooth structure, (d) separation of instruments used to treat the tooth, (e) perforation of the root with instruments, (f) underfill and overfill of the canal; sinus perforation, (g)damage to bridges, existing fillings, crowns or veneers, (h) non-negotiable canals due to fillings, prior treatment, natural calcifications, severely curved roots, root resorptions.

Treatment will be performed in accordance with accepted methods of clinical practice. Digital images will be taken before, during and after treatment as indicated. Local anesthetic is used to anesthetize (numb) your tooth. Although complications are rare, local anesthetic injections complications include the following: swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth which is usually temporary but can be permanent, jaw muscle cramps and spasm, trismus, rapid heartbeat and allergic reactions.

Patients with existing crown, bridge, onlay or inlay restoration: A crown, bridge, onlay and inlay may need to be replaced following endodontic therapy. Replacement is often needed if a cavity has damaged the restoration's integrity. The restoration may also need to be replaced if it is not able to withstand the stress of making the endodontic access to perform the elected endodontic treatment. Normally, endodontic therapy can be successfully done through a crown, bridge, onlay or inlay without incident 95% of the time. Completing endodontic therapy may also result in you needing to replace your restoration. We want everyone to understand this because replacing a restoration adds unanticipated expenses that are our patient's responsibility. It is important for us that you understand that we go to great lengths to preserve the integrity of your restoration. As your healthcare provider, I am directly informing you that should any damage occur to the crown, bridge, onlay or inlay, you-the patient, accept full responsibility for fabrication of a new restoration. It is not our responsibility to fabricate or pay to fabricate a new restoration for you.

By signing below, I fully understand the potential for damage and accept all responsibility replacing the restoration should the situation arise. I hereby give my consent to the performance of endodontic treatment. I further give my consent for the administration of medications, anesthetics, and services deemed necessary to treat my endodontic problem, understanding the risks involved.

I hereby authorize and request you to release to my dentist and/or insurance companies the complete dental records in your possession concerning the treatment in this office.

_____ _____

Signature of patient or legal designate Date

_____

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Insurance Information

As a courtesy to patients, Commonwealth Endodontics will file claims with all insurance companies. We are contracted with the following providers:

- Delta Dental PPO
- DeCare (Delta Care)
- Anthem Blue
- Anthem PPO
- Cigna PPO
- Guardian PPO
- Aetna PPO
- Metlife
- Veterans Affairs
- Dentamax
- Assurant

For the carriers listed above, we collect based on the percentage for services and/or benefits available that the insurance provider estimates for the patient.

If you have any questions about your benefits, please ask one of our team members to help you.

Please read and initial beside the section that applies to your situation.

_____ Patients **without** dental insurance: **Payment is expected in full, at the time of treatment, for all services rendered.**

_____ Patients **with** dental insurance: As a courtesy to patients, CWE will verify the coverage your insurance plan offers prior to your appointment and provide you an estimated cost of services. Please remember that this is an estimate and not a guarantee of payment. You are ultimately responsible for the balance of your account, including any portion the insurance company does not cover. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. CWE will gladly file all insurance claims on your behalf. The insurance co-payment is to be paid at the time of treatment and all insurance benefits are payable directly to Commonwealth Endodontics. When all insurance claims have been received, if any overpayment has been made, a refund will be mailed promptly to you. If there is an additional amount due, we will send a statement of balance, which will then be payable in full upon receipt. **Each patient is fully responsible for his or her own account and any amount not covered by insurance.**

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Payment Information

At Commonwealth Endodontics, it is our goal to save your tooth and provide each patient a great experience and excellent dental care. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Please be advised there are some procedures the doctor may need to perform during your visit that most insurance companies do not cover. The statements below outline the fee structure for the most common services. To maximize your insurance reimbursement, CWE will file all insurance claims for all procedures performed on your behalf. If your insurance provider covers any of the services listed below, a refund will promptly be mailed to you.

PLEASE READ AND INITIAL NEXT TO EACH SCENARIO OF SERVICE LISTED BELOW stating that you fully understand payment is expected in full, the day of your treatment visit.

_____ If treatment is initiated on your tooth and it is discovered that your tooth cannot be saved by root canal therapy, you will not be charged the full cost of the treatment, however, **there is an inoperable fee of $487 for the services that the doctor completed on your tooth during your treatment session. This fee is due in full the same day as your appointment.** If a tooth extraction is required, CWE will refer you back to your dentist or to an oral surgeon. Commonwealth Endodontics does not extract teeth.

_____ There is a $130 service fee if you select to receive Nitrous Oxide during your treatment session.

_____ Your doctor may recommend a CBCT scan, which is a 3D panoramic x-ray of your mouth/teeth. This x-ray will give the doctor a complete view of your infected tooth to perform your treatment. The service fee for a CBCT scan is $196.

NOTE: Accounts will be turned over to a collection agency if the balance is not paid in full within 60 days.

A $25.00 charge will be added to your account for all RETURNED CHECKS.

I have read and fully understand the above insurance and payment information.

_____ _____

Signature of patient or legal designate 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 Practices.

Signature: _____

Date: _____

I give Commonwealth Endodontics permission to exchange information with the following people:

NAME	RELATIONSHIP	PHONE #

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
- □ Communication barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please specify)