SOUTHTOWNS ENDODONTICS

Michael Vatral, DDS,MS; Paul G. Calabrese,DDS,MS

PATIENT REGISTRATION FORM:

PATIENT NAME:_____

STREET ADDRESS:_____

TOWN/CITY/ZIP:_____

HOME PHONE:_____SOCIAL SECURITY:_____

DATE OF BIRTH:_____

EMPLOYER:_____WORK NUMBER:_____

EMPLOYER ADDRESS:_____

REFERRING DENTIST:_____ PHONE #:_____

ADDRESS:_____

PHARMACY NAME:_____PHARMACY #:_____

DO YOU HAVE DENTAL INSURANCE? YES NO (PLEASE CIRCLE)
INS. INFORMATION MUST BE COMPLETE AND ACCURATE FOR REIMBURSEMENT-ID/SOCIAL SECURITY # IS REQUIRED
See financial policy regarding office policy and procedure regarding insurance)
NAME OF DENTAL PLAN:_____

DENTAL PLAN ADDRESS IF AVAILABLE:_____
(SUPPLY INSURANCE CARD IF YOU HAVE ONE)

MEMBER NAME:_____
MEMBER/EMPLOYEE ID/SOCIAL SECURITY NUMBER:_____

MEMBER/EMPLOYEE GROUP NUMBER:_____
MEMBER DATE OF BIRTH:_____

EMPLOYER:_____EMPLOYER ADDRESS:_____

DO YOU HAVE SECONDARY INSURANCE? YES NO
(PLEASE CIRCLE) if so, that information is also needed.

Health History

*****PLEASE TURN OVER TO COMPLETE*****

Name: (Last) _____ (First) _____

Date of birth: _____

Are you in good health? _____ yes no

Any change in health in past year? _____ yes no

Please explain: _____

Are you under the care of a medical doctor? _____ yes no

Please explain: _____

MD name/address: _____

Any hospitalizations within the past 5 years? _____ yes no

Serious illnesses or operations? _____ yes no

Any problem with previous dental treatment? _____ yes no

Any history of abnormal bleeding? _____ yes no

Women: Are you pregnant? _____ yes no

Do you have or have you had any of the following?

1) Cardiovascular disease?
(heart trouble, heart attack, stroke, pacemaker, stent) _____ yes no
2) Rheumatic fever or rheumatic heart disease? _____ yes no
3) Congenital heart problems? _____ yes no
4) Irregular heart beat, heart murmur, mitral valve prolapse? _____ yes no
5) High blood pressure? _____ yes no
6) Shortness of breath when lying down? _____ yes no
7) Allergies (other than to medication)? _____ yes no
8) Asthma? _____ yes no
9) Fainting spells or seizures? _____ yes no
10) Diabetes _____ yes no
11) Dry mouth? _____ yes no
12) Liver problems (hepatitis, jaundice, liver disease)? _____ yes no
13) Stomach problems, ulcers? _____ yes no
14) Kidney problems? _____ yes no
15) Sexually transmitted disease? _____ yes no
16) Thyroid problems? _____ yes no
17) Blood disorder? _____ yes no
18) Surgery or X-ray treatment of head/neck? _____ yes no
19) Do you have any prosthetic replacement(joint, hips, knee, or other yes no

Medication allergies:

antibiotics (ie: Penicillin, sulfa drugs) _____ yes no
local anesthetic _____ yes no
aspirin _____ yes no
narcotics (ie: codeine, hydrocodone) _____ yes no
other medication allergies _____ yes no

Are you taking any of the following medications?

antibiotics
blood pressure medication
tranquilizers
heart medication
birth control pills
blood thinners
steroids
diabetes medication
nitroglycerin
aspirin

Please list the names of any medications, pills, liquids, or tablets you are taking:

_____

_____

Signature of patient:_____ Date:_____

Signature of Dentist:_____ Date:_____

Medical History Updates

Date:_____ Changes:_____

Date:_____ Changes:_____

Date:_____ Changes:_____

Date:_____ Changes:_____

SOUTHTOWNS ENDODONTICS
NOTICE OF PRIVACY PRACTICES

OUR LEGAL DUTY: *We are required by applicable federal and state law to maintain the privacy of your health information and give you this notice. We must follow the privacy practices described in this notice which takes effect April 14, 2003 and will remain until we replace it. We reserve the right to change our privacy practices.*

Uses and disclosure of health information: we use and disclose health information about you for treatment, payment, and health care operations.

Treatment: we may use or disclose your health information to a physician or other healthcare provider(s) providing treatment to you.

Payment: we may use and disclose your health information to obtain payment for services we provide to you.

To your family and friends: we may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

*PATIENT NAME:*_____

*PATIENT SIGNATURE:*_____

*TODAYS DATE:*_____

SOUTHTOWNS ENDODONTICS
FINANCIAL POLICY
Effective 1/1/2025

****FOR THOSE WITHOUT INSURANCE****

PAYMENT IS DUE AT THE TIME SERVICE

********FOR THOSE WITH INSURANCE*******

For those with dental insurance the most accurate way to determine what your coverage will be is to request a pre-treatment estimate from your insurance company. We will gladly obtain an estimate for you if you wish.

For the following insurance plan, we are participating providers. **NO PAYMENT** is due at the time of service with the possible exception of a CBCT scan (3D x-ray) if needed. A claim will be filed with your insurance company after treatment has been completed. Once payment is received from your insurance company, a **bill** will be sent to you for any **outstanding balance** as most insurance companies **DO NOT COVER 100% OF TREATMENT COSTS**.

We are participating providers with:

Highmark (United Concordia)

For all other insurance plans, payment is due at the time of service

A claim will be filed once treatment has been completed and payment will be sent directly to you. Please be sure to provide accurate insurance information to maximize your reimbursement.

We also accept Care Credit.

*Please note that we are not providers for Medicare and you may not be entitled to reimbursement.

SOUTHTOWNS ENDODONTICS FINANCIAL POLICY
Effective 7/15/2019

Please carefully read our financial policies. Please ask any questions about your financial responsibility before treatment begins.

If you do not have dental insurance, or if you have insurance that we are not participating providers for, fees are payable at the time of service.

If you have dental insurance for which we are a participating provider, a claim will be filed once treatment is completed. It is rare that your insurance will cover the entire cost of treatment. Any balance remaining after payment is received from your insurance company is your responsibility. Please see "**For Those With Insurance**" page.

Please provide us with current and accurate insurance information prior to your treatment. This will expedite filing of your claim. Without it, you may be responsible for charges that otherwise would be covered

A $5.00 billing fee or a 1.5% monthly service charge will be added to outstanding balances not paid within 30 days of billing. If your account is sent to our collection agency, all legal fees and collection fees will be added to the outstanding balance.

The charge for a returned check is $25.

Accident/Trauma/Workers Compensation Cases: The patient is responsible for any and all treatment charges. We will complete any necessary paperwork to help you obtain reimbursement, if that information is provided to us.

Guardianship Cases: The parent/guardian accompanying the child is responsible for payment.

We participate with the **Thank a Vet Discount** program.

Please sign below agreeing that you have read and understood our financial policy and your responsibility associated with your treatment.

Signature:_____ Date:_____

Print:_____

SOUTHTOWNS ENDODONTICS
3D XRAYS

In some cases, we **MAY** recommend additional x-ray images. 3D dental x-rays (also known as CBCT, or cone beam x-rays) are being used extensively in many areas of dental treatment, including endodontics (root canals). The amount of information obtained from these images is vastly superior to 2D (traditional) x-rays, with low radiation exposure.

*****THIS IS UNLIKELY TO BE COVERED BY DENTAL INSURANCE. THE FEE IS $295, PAYABLE AT THE TIME THE IMAGE IS TAKEN.*****

(We will submit an insurance claim on your behalf in case there is coverage.)

Please Initial:_____Date:_____

CONSENT FOR DENTAL TREATMENT

SOUTHTOWNS ENDODONTICS

Patient Name: _____

DOB: _____/_____/_____

I hereby authorize ***Dr. Michael Vatral/Dr. Paul Calabrese***, and or assistants to perform routine dental treatment and/or any other treatment or procedure that his/her dental judgement dictate during said treatment and/or procedure.

I also acknowledge that the practice of dentistry is not an exact science and that no guarantees or assurances have been made concerning the results of the treatment and/or procedure. I realize there is no guarantee the root canal treatment will save my tooth, and that complications can occur from the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

I understand that I will be given full opportunity for discussion and questions concerning the treatment and/or procedure to be performed. ***I also understand that it is my responsibility to contact my general dentist for permanent restoration placement.***

_____

Signature of Patient or Alternative Consenting Party if patient is unable to sign or is a minor.

Alternative Consenting Party's relationship to Patient: _____

DENTISTS CERTIFICATION

I certify that I have discussed or offered to discuss with the patient (or if the patient was unable to sign, the alternate consenting party) he treatment and/or procedure to be performed, its alternatives and reasonable foreseeable risks and benefits in a manner so as to permit the consenting person to make a knowledgeable decision.

Signature: _____DDS, MS

Date: _____/_____/_____

Consent for Endodontic (Root Canal) Treatment

Patient's Name:_____ **Tooth #**_____

The **benefits** of successful root canal treatment include the **relief of pain and the ability to retain the tooth in comfort and function.**

The risks of endodontic treatment include:

Possibility of separated instruments which may prevent successful treatment.

Blocked root canals which may prevent successful treatment.

Perforations (accidental openings) of the crown or root of the tooth.

Loss of tooth structure/weakening of tooth.

Identification of crown or root fracture during or after treatment.

Post-operative pain, swelling, and/or infection.

Damage to existing crowns, bridges, or other appliances.

A 5-10% chance of failure.

Extension of disinfectants, medicaments, or filling materials beyond the end of the root.

Jaw joint tenderness following treatment.

Nerve disturbances that can result in temporary or permanent numbness.

Treatment alternatives include: No treatment, extraction.

Treatment may require administration of drugs: Such as local anesthetics, antibiotics, analgesics.
Potential risks include: Pain, injury to nerves or blood vessels, allergic reaction.

I understand that during treatment, complications may arise which complicate or make treatment more difficult, or which may require additional dental surgery.
The dentist has explained to me the need for a permanent restoration which adequately protects the tooth after root canal treatment has been completed **and that this procedure is not included in the root canal fee.** I understand that no guarantee of success has been or can be given. All of my questions have been answered and I fully understand all the above statements contained in this consent form.

Dentist's Signature:_____ DDS Date:_____

Patient's Signature:_____ Date:_____