Palmetto Endodontics, LLC

Specialists in Saving Teeth

PATIENT INFORMATION *(Please provide Photo ID with completed paperwork)*

Last Name: ________________________________ First Name: ______________________ MI: ____________

Please Circle One: Mr. Mrs. Ms. Other______________________

Address: ________________ City: ______________________ State: ______________ Zip: ______________

Home Phone: ______________________ Work Phone: ________________ Cell Phone: __________________

Preferred Name: __________________________ Email: ____

**By providing us with your phone numbers and email address, you consent to being contacted by these methods for appointment related purposes.*

Please Circle One: Male Female SSN: _____________________________ Date of Birth: _______________

Name of your Employer: ____

Name of Your Referring Dentist: ____

DENTAL INSURANCE INFORMATION *(Please provide card with completed paperwork)*

Name of Ins. Company: ____________________________ Employer: _________________________________

Patient's Relationship to Subscriber *(Please circle one):* **POLICY HOLDER SPOUSE CHILD OTHER**

Subscriber's Name EXACTLY as it appears on card: ____

Subscriber's Date of Birth: __________________________ ID/SSN: ___________________________________

If the patient is a minor, person responsible for payment: ____

PLEASE PROVIDE SECONDARY INSURANCE INFORMATION BELOW (WHEN APPLICABLE)

Name of Ins. Company: __________________________ Employer: ____________________________________

Subscriber's Name: __________________________ SSN/ID#: __________________ DOB: ______________

HEALTH HISTORY:

Primary Care Physician's Name:_______________________________________

***Women Only*: Are you pregnant or nursing? Yes / No**

MEDICATIONS *(Please indicate ALL medications you are currently taking)*

Antibiotic:________________________________ Cortisone/Steroids: _______________________________

Pain Med: _______________________________ Blood Thinners: ___________________________________

Heart Med:_______________________________ Blood Pressure:___________________________________

Aspirin:__________________________________ Osteoporosis: ____________________________________

Please list any other medications not mentioned above here:______________________________________

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ALLERGIES *(Please circle ALL allergies)*

Penicillin	Demerol	Local Anesthetic	Sulfa
Codeine	Latex	Aspirin	Erythromycin

Please list any other allergies not mentioned above here:____

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MEDICAL CONDITIONS *(Please circle ALL medical conditions)*

Heart Condition	Diabetes	Thyroid/Hormone Disorder
High Blood Pressure	Tuberculosis	Surgery (Heart/Joint Replacement)
Low Blood Pressure	Fainting	Stroke
Rheumatic Fever	Kidney/Liver/Stomach	Epilepsy
Asthma	HIV	Radiation Treatment/Chemo Therapy
Blood Disorders	Hepatitis	

Please list any other conditions not mentioned above here: ______________________________________

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EMERGENCY CONTACT INFORMATION

Name:_______________________________________ Telephone: ______________________________

Relationship:____

PHARMACY INFORMATION

Name:_______________________________________ Telephone: ______________________________

Address: ____

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CONSENT TO ENDODONTIC THERAPY

Please review the following consent and sign it; however, it does not commit you to treatment. If you have any questions or if there is anything you do not understand about the endodontic procedure, please ask the doctor when he or she reviews your treatment and options during your appointment.

This is my consent to the endodontic procedures indicated and any other procedures deemed necessary or advisable as a corollary to the planned endodontic therapy performed by any of the endodontists employed by Palmetto Endodontics, LLC and any assistants with whom they work. I agree to the use of local anesthesia, depending upon the judgement of the endodontist. I understand the endodontist will consult with me prior to administering any sedation, and/or nitrous oxide analgesia. Complications of root canal therapy and anaesthesia may include swelling, bruising, pain, trismus (restricted jaw opening), infection, bleeding, sinus involvement, and numbness or tingling of the lip, gum, or tongue, which is rarely protracted and even more rarely is it permanent. I understand that it is my responsibility to report any symptoms to the endodontist immediately.

I understand that root canal therapy is a procedure to retain a tooth, which may otherwise require extraction and that as a specialty practice; the office performs only endodontic therapy and associated surgery. Although root canal therapy has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth that has had root canal therapy may require retreatment, surgery or even extraction. Following treatment, the tooth may be brittle and subject to fracture. A restoration (filling), crown, and/or post and core will be necessary to restore the tooth to function; your general dentist will perform this. During treatment there is the possibility of instrument separation within the root canals, perforations (extra openings), damage to bridges, existing fillings, crowns, or porcelain veneers, missed canals, loss of tooth structure in gaining access to the canals and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when a tooth may not be amenable to endodontic treatment at all. Other choices include no treatment, waiting for more definitive symptoms to develop, or tooth extraction. Risks involved in those choices might include but are not limited to pain, infection, swelling, loss of teeth, and infection to other areas.

At times, medications will be prescribed by the endodontist. I understand that medications for discomfort and sedation may cause drowsiness, which can be increased by the use of alcohol or other drugs. I am advised against the use of alcohol or operating any vehicle or hazardous devices while taking such medications. I further understand that certain medications may cause hives and intestinal problems and if any of these reactions occur, I am to call the endodontist immediately. I understand that it is my responsibility to report any changes in my medical history to the endodontist.

With regard to financial obligation, I understand that I am financially responsible for charges related to examination and/or treatment at the time services are rendered. In the event insurance is a factor, I agree to be responsible for all charges for dental services and materials not paid for by my dental carrier. Any fees associated with collecting a past due balance may also be assessed to my account. These fees include but are not limited to fees charged by a collections agency, attorney fees, certified letter fees or any court fees.

Printed Name: ____________________________

Signature: ________________________________ Date: _______________

OFFICE USE ONLY

PT Chart #: __________________________ Witness: ______________________________

4023 Forest Dr., Columbia, SC 29204 | 140 Summit Centre Dr., Columbia, SC 29229 | 322 W. Main St., Lexington, SC 29072
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www.palmettoendodontics.com

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HIPPA

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. 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 use and disclose health information about you for treatment, payment, and healthcare operations. For example, we may use or disclose your health information to a physician or other healthcare provider providing treatment to you. We may use and disclose your health information to obtain payment for services we provide to you.

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 disclose it to anyone for any purpose. If you give us an authorization, you may revoke in writing at any time. 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 with payment for your healthcare, 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.

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.

I give my permission to discuss billing and treatment with the following:

Name: ______________________________ **Relationship to Patient:** ______________________________

Patient Name:____

Legal Guardian:____

Date:_______________________

Palmetto Endodontics, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have a received a copy of this office's Notice of Privacy Practices.

____
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**
- ☐ **Communication barriers prohibited obtaining the acknowledgement**
- ☐ **An emergency situation prevented us from obtaining acknowledgement**
- ☐ **Other (Please Specify)** ______________________________

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