Renaissance Endodontics, PLLC

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.

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 this 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 February 15 2004, 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.

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 to 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 qualifications 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 a 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, 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 our experience with common practice to make reasonable inferences of your best interest in 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.

Patient Registration Form

Patient Information

Patient's General Dentist	How long have you been a patient of general DDS?	Who referred you (If not your general DDS)?
Patient Name	Sex: Male□ Female□	D.O.B. / Age
S.S.N. / Employer	Occupation	Marital Status
Street Address	City & State / Zip Code	Best Contact Phone #
Name of Emergency Contact:	**Relation:** / **Home Phone #**	**Work Phone #**
Is this visit related to an accident Yes □ No □	If yes, date of injury	Brief description
Email address:		

Primary Dental Insurance Information

Subscriber/Policy Holders Name	Are you: Subscriber□ Spouse□ Dependent□ Hourly□ Salary□
Street Address (If Different form Above) / City & State / Zip Code / Home Phone # / D.O.B.	
S.S.# / Contract # / Dental Insurance Company / Code / Group # / % Coverage / Service Code	
Name and Address of Employer / City & State / Zip Code / Business Phone #	

Secondary Dental Insurance Information

Subscriber/Policy Holders Name	Are you: Subscriber□ Spouse□ Dependent□ Hourly□ Salary□
Street Address (If Different from Above) / City & State / Zip Code / Home Phone # / D.O.B.	
S.S.N. / Dental Insurance Company / Code / Group # / % Coverage / Service Code	
Name and Address of Employer / City & State / Zip Code / Business Phone #	

Patient Health Questions

Patient Name:_____

	Yes	No
1. Have you ever had root canal therapy?		
2. Do you have or have you ever been treated for:		
a. Heart trouble; Rheumatic fever; Mitral valve prolapse; Artificial heart valve, pacemaker or Heart murmur? (If so circle one)		
b. High blood pressure?		
c. Chest pain?		
d. Diabetes?		
e. Dialysis?		
f. Hepatitis, Liver disease?		
g. Tuberculosis?		
h. Blood disorder, such as, anemia?		
i. History of blood transfusion?		
j. Herpes?		
k. AIDS, HIV positive or positive for AIDS virus? (If so circle one)		
l. Artificial joints or implants?		
m. Lung diseases; Asthma, Bronchitis, Emphysema? (If so circle one)		
n. Epilepsy, Multiple sclerosis or Glaucoma? (If so circle one)		
o. Ulcer?		
p. Thyroid disease?		
q. Malignant tumor, chemo therapy or radiation therapy? If so explain:		
r. Malignant hypothermia?		
3. Have you ever experienced or been told you have;		
a. TMJ (Temporomandibular joint disease) or clicking of the jaw? (If so circle one)		
b. Difficulty opening or Muscle spasms in your jaw? (If so circle one)		
4. Difficulty breathing through your nose?		
5. Hay-fever / sinus problems? (If so circle one)		
6. Have you ever had a prolonged bleeding from an injury, tooth extractions, etc?		
7. Bruise easily?		
8. Have you ever had a reaction from a local anesthetic?		
9. Have you experienced any illness or complications following dental treatment of any kind? If so explain:		
10. Are you allergic to any drugs, medications or to latex? If so list:		
11. Are you taking any drugs or medications at this time? If so list:		
12. Do you have a history of chemical dependency?		
13. Do you have family history of cancer, heart disease or diabetes? (If so circle)		
14. Did you have any alcoholic beverages today?		
15. Do you have, or have you recently had any evidence of infections or sore throat?		

16. Have you been hospitalized or under the care of a physician this past year?		
	Yes	No
17. Do you have any disease, condition or problem the doctor should know about? If so explain:		
18. Women: Are you pregnant? If so how many months?		
19. Women: Are you taking birth control pills		
20. Have you ever had a root canal by one of our doctors? If so, by whom? When?		

21. What is the impression of your present teeth: Good □ Fair □ Poor □

22. How did you hear about us?
(check all that apply) ✓

Explain:

Renaissance Endodontics Website □ _____

General Dentist □ _____

Insurance Carrier □ _____

Friend/Family Member □ _____

Yellow Pages Ad □ _____

Magazine Ad □ _____

Television Ad □ _____

My answers to the above questions are true to the best of my knowledge.

Patient / Guardian Signature **Date**

Attending Doctor Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

Patient / Guardian Signature **Date**

Revised 02/17/2009

Endodontic Consent and Information Form
Root Canal Therapy, Anesthetics and Medications

We would like to inform you of the various procedures involved in endodontic therapy and have you consent before starting treatment. Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by conservative root canal therapy. The following discusses possible risks that may occur from endodontic treatment and other treatment choices.

RISKS: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections. These complications include: swelling; sensitivity; bleeding; pain; infection; numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, which is transient but on rare occasions may be permanent; reaction to injections; changes in occlusion (biting); jaw muscle cramps and spasms; temporomandibular (jaw) joint difficulty; loosening of teeth, referred pain to ear, neck and head; nausea; vomiting; allergic reactions; delayed healing, and treatment failure.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY: The risks include the possibility of instruments broken within the root canals; perforations (extra openings) of the crown or root of the tooth; damage to bridges, existing fillings, crowns or porcelain veneers, loss of tooth structure in gaining access to canals, and cracked teeth. During treatment, complications may be discovered which make treatment impossible, or which may require dental surgery. These complications may include: blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), splits or fractures of the teeth.

MEDICATIONS: Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be intensified with the use of alcohol, tranquilizers, sedatives or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from the effects of the medications and drugs.

OTHER TREATMENT CHOICES: These include no treatment, waiting for more definite development of symptoms, or tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infection to other areas.

CONSENT: I, the undersigned, being the patient, parent or guardian, consent to the performing of procedures decided upon to be necessary or advisable in the opinion of the doctor. I also understand that upon completion of root canal therapy in this office, I shall return to my general family dentist for a permanent restoration of the tooth involved, such as a crown, cap, jacket, onlay or silver filling. I realize that a check up x-ray should be taken in 6 months by my own general dentist or by the treating endodontist.

Although root canal therapy has a very high degree of clinical success, it is still a biological procedure and cannot be guaranteed. Variations in anatomy and canal location may compromise success. Occasionally, a tooth which has had root canal therapy may require treatment, surgery or even extraction. My questions have been answered to my satisfaction. I have carefully read the above statements and give my consent for the procedure.

The purpose of this document is not to alarm you. We have been advised not to begin treatment on anyone who has not read and signed this form.

SIGNATURE OF PATIENT OR GUARDIAN_____DATE_____

SIGNATURE OF WITNESS_____DATE_____

RENAISSANCE ENDODONTICS, PLLC

WE WILL SUBMIT YOUR INSURANCE FORMS FOR YOU, HOWEVER, WE DO NOT KNOW IF THEY WILL PAY ANY OF THE CLAIM. IF THE INSURANCE COMPANY DOES NOT PAY, THE PATIENT REMAINS RESPONSIBLE FOR THE PAYMENT.

Because of the nature of the referral work, we must respectfully request that all patient balances be paid prior to completion, if unable to do so please advise us now. Time Payments are available only through Master Card, Visa, Discover Card, American Express, or Check.

FINANCIAL POLICY – FOR PATIENTS WITH DENTAL INSURANCE

Our experience with over 500 dental insurance contracts shows us that misunderstandings most often occur concerning co – payment. Please read the statement below and sign.

I understand that my dental insurance will only pay a portion of the cost of my treatment and that **my portion is due no later than the time of treatment.**

The amount that the insurance company states they will pay is **only an estimate that has been obtained over the telephone.**

If the insurance company pays a lesser amount, or denies my claim, I will receive a statement to that effect and it will be my responsibility to pay the difference. If they pay more, I will be sent a refund.

If the insurance does not make payment within 45 days after the form is sent in, I will assume immediate responsibility for the payment and deal with the insurance company myself.

So that our staff can properly administer your account, please indicate below how you will be taking care of your balance:

CASH□ CHECK□ VISA□ MASTERCARD□ DISCOVER□ AMERICAN EXPRESS□ CARE CREDIT□

I authorize release of any information relating to this claim. I have reviewed the treatment plan and I hereby authorize payment directly to the attending dentist of the group insurance benefits otherwise payable to me.

Signature **Date**

Revised 11/20/2019

COVID-19 Pandemic Emergency Dental Treatment Consent Form

I, _____, knowingly and willingly consent to have emergency dental treatment completed during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limit in virus testing.

Dental procedures create water spray which is how the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

- I understand that due to the frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office. _____(Initial)
- I have been made aware of the CDC, ODA, and ADA guidelines that under the current pandemic all non-urgent dental care is not recommended. Dental visits should be limited to the treatment of pain, infection, conditions that significantly inhibit normal operation of teeth and mouth, and issues that may cause anything listed above within the next 3-6 months. _____(Initial)
- I confirm I am seeking for a condition that meets these criteria. _____ (Initial)

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

- Fever
- Shortness of Breath
- Dry Cough
- Runny Nose
- Sore Throat
- My temperature today is: _____
    - I have not taken any fever reducing medications (Motrin/Tylenol). If yes: Time/Date _____
- _____ (Initial)

I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. And the CDC recommends social distancing of at least 6 feet for a period of 14 days to anyone who has, and this is not possible with dentistry. _____ (Initial)

- I verify that I have not traveled outside of the United States in the past 14 days to countries that have been affected by COVID-19. _____ (Initial)
- I verify that I have not traveled domestically within the United States by commercial airline, bus, or train within the past 14 days. _____ (Initial)

Name _____ Date _____