Endodontics, P.C.
Matthew P. Friedt, D.D.S.

2006 Franklin Street, Suite 209 Huntsville, Alabama 35801 Telephone: (256) 533-1723

Today's Date: ________________________

Patient Information

Patient Name: ______________________________ Date of Birth: ____________ Sex: M F

Home Address: ____________________________ City: ____________ State: ______ Zip: ______

Home Phone: ________________ Work Phone: ________________ Cell Phone: ______________

Email Address: ____

Referring Dentist: ____

Employer: ______________________________ Occupation: __________________________

Social Security Number: ____

Emergency Contact Name: ____________________________ Phone: ____________________

Person Responsible for Account and Payment: ____

*Medicare does **not** cover root canal treatment and we are not a Medicare provider. All procedures in our office are dental and therefore **not** covered under medical insurance. We do not file any medical insurance.*

Primary Dental Insurance

Name of Insured/Subscriber: ________________________________ Date of Birth: ____________

Patient Relationship to Insured/Subscriber: (please circle) SELF SPOUSE CHILD OTHER

Insured/Subscriber Employer: ____

Insurance Company Name: ____

Group Number: ________________________ Contract or Policy ID Number: __________________

Insured/Subscriber full Social Security Number: _____________________________________

Secondary Dental Insurance

Name of Insured/Subscriber: ________________________________ Date of Birth: ____________

Patient Relationship to Insured/Subscriber: (please circle) SELF SPOUSE CHILD OTHER

Insured/Subscriber Employer: ____

Insurance Company Name: ____

Group Number: ________________________ Contract or Policy ID Number: __________________

Insured/Subscriber full Social Security Number: _____________________________________

Office Payment Policy - with or without Dental Insurance Coverage

To avoid misunderstandings concerning our payment policy, please read the following.

This is a referral practice, and a mutual respect to obligations is essential to permit our business to be conducted on an efficient and friendly basis. Therefore, to avoid misunderstandings concerning payments of account, please note that endodontic treatment is usually completed in one or two visits, and must be paid in full at start of service. Our Endodontic, P.C., Matthew P. Friedt, DDS, practice does not accept monthly payment plans. For your convenience we accept major credit cards, cash, checks and care credit as methods of payment.

We will be happy to file dental insurance claims for you as a courtesy, however you must understand that your dental insurance is a contract between you as a subscriber, and your dental insurance company, and indirectly involves our practice, Endodontics, P.C., Matthew P. Friedt DDS. Therefore, any controversy which might arise over your dental insurance company's handling of your claim is for you to resolve. Any discrepancy between the dental insurance company's allowance and your total indebtedness remains YOUR responsibility. Any dental insurance claim that has not been paid within 60 days of treatment will be billed back to you. Be informed that withholding any dental insurance information by you, may constitute fraud.

I hereby assign, transfer, and set over to Endodontics, P.C., Matthew P. Friedt, DDS, all rights, title and interest to my dental reimbursement benefits under my dental insurance policy. I authorize the release of any dental information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand I am financially responsible for all charges for my dependents or myself whether or not they are covered by dental insurance. I, the undersigned, hereby agree, in the event of default in the payment of any amount due, of if this account is placed in the hands of a collection agency or attorney for collection or legal action, I agree to pay additional charges equal to the cost of collections, which can be up to 40%, in addition to collection agency and attorney fees, office administrative fees and court costs incurred. I grant my permission to you, or your assigns, to telephone me at home, or at my work or on my cell phone to discuss matters related to this form.

____ ____________________

Signature of Patient or Guardian Date

Acknowledgement of Receipt of Notice of Privacy Practices

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

(Copy of Privacy Practices is available in printed format and displayed in office at sign-in counter)

____ ____________________

Signature of Patient / Parent or Legal Guardian Date

If signed by other than patient, specify relationship to patient: ______________________________

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Patient Name: (Print) ______________________________________ Date: _______________

Endodontic Consent and Information Form

We would like our patients to be informed about the various procedures involved in endodontic therapy and have their 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, or when needed, endodontic surgery. The following discusses possible risks that may occur from endodontic treatment, and other treatment choices.

RISKS: 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), or splits or fractures of the teeth.

MEDICATIONS: Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effects. Any antibiotics (penicillin, Keflex®, erythromycin, etc.) that may be prescribed, can reduce the effectiveness of oral birth control medications for two weeks after last dose. Antibiotics can also react with certain sinus medications. Please ask me and/or your pharmacist if you have any questions. If you are taking medications, check with your pharmacist about interactions.

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 of minor patient) 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 understand that root canal treatment is an attempt to save a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery or even extraction.

PATIENT SIGNATURE: ____ DATE: ______________

GUARDIAN OR PARENT SIGNATURE AND DATE (IF PT IS MINOR): ____

HEALTH HISTORY

Endodontics, P.C.

Patient Name: ______________________________ Today's Date: ______________

Birthdate: ____________________ Sex: ❑ Male ❑ Female

In the past year have you had any serious illness, operations or hospitalizations? ❑ Yes ❑ No

Are you under a physician's care at this time? ❑ Yes ❑ No Name of physician: ______________

Do you typically pre-medicate prior to your dental treatment with antibiotics? ❑ Yes ❑ No Reason:__________

Do you have or did you ever have any of the following?

Cardiovascular Health

High blood pressure ❑ Yes ❑ No
Angina or heart attack ❑ Yes ❑ No
Chest pain on physical exertion ❑ Yes ❑ No
Coronary artery blockage or treatment (bypass,stent, etc.) ❑ Yes ❑ No
Heart valve problem or replacement ❑ Yes ❑ No
Heart murmur ❑ Yes ❑ No
A-fib ❑ Yes ❑ No
Irregular heartbeat or pacemaker ❑ Yes ❑ No
Difficulty breathing when lying down ❑ Yes ❑ No
Stroke ❑ Yes ❑ No
Low blood pressure ❑ Yes ❑ No
Cholesterol ❑ Yes ❑ No

Respiratory Health

Asthma ❑ Yes ❑ No
Emphysema or respiratory problems ❑ Yes ❑ No
Chronic sinus problems ❑ Yes ❑ No
Tuberculosis or persistent cough ❑ Yes ❑ No

Endocrine/Blood/Immune Health

Diabetes ❑ Yes ❑ No
Thyroid problems ❑ Yes ❑ No
Abnormal bleeding, bruise easily ❑ Yes ❑ No
Hemophilia ❑ Yes ❑ No
Anemia/blood disease ❑ Yes ❑ No
Cancer ❑ Yes ❑ No
Radiation therapy/chemotherapy ❑ Yes ❑ No
HIV infection/AIDS ❑ Yes ❑ No
Cold sores/canker sores ❑ Yes ❑ No
Organ transplant ❑ Yes ❑ No
Blood transfusion ❑ Yes ❑ No

Muscular-Skeletal/CNS/Mental Health

Joint replacement ❑ Yes ❑ No
Arthritis ❑ Yes ❑ No
Osteoporosis ❑ Yes ❑ No
Fainting spells or dizziness ❑ Yes ❑ No
Seizures ❑ Yes ❑ No
Numbness or muscle weakness ❑ Yes ❑ No
Multiple sclerosis ❑ Yes ❑ No
Dementia/Alzheimer's disease ❑ Yes ❑ No
Anxiety/Nervousness ❑ Yes ❑ No
Mental health treatment ❑ Yes ❑ No

Gastro-Intestinal/Genito-Urinary Health

Hepatitis (A, B, C or other) ❑ Yes ❑ No
Liver disease ❑ Yes ❑ No
Kidney disease/dialysis ❑ Yes ❑ No
Stomach trouble/ulcers ❑ Yes ❑ No
Sexually transmitted disease ❑ Yes ❑ No

Medication Allergies and Other Allergies

Penicillin ❑ Yes ❑ No
Sulfa drugs ❑ Yes ❑ No
Dental anesthetic ❑ Yes ❑ No
Aspirin ❑ Yes ❑ No
Codeine/narcotics ❑ Yes ❑ No
Iodine ❑ Yes ❑ No
Latex products ❑ Yes ❑ No
Metals/nickels/jewelry ❑ Yes ❑ No
Other: ❑ Yes ❑ No

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Females Only

Are you Pregnant ❑ Yes ❑ No Nursing ❑ Yes ❑ No
Taking birth control ❑ Yes ❑ No

Do you or have you used bisphosphonate medication (Fosomax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa, Bonefos)? ❑ Yes ❑ No

Do you have any diseases or medical conditions not listed on this form? ______________________

Medications

List any prescription mediciations, over the counter medications or herbal medications that you take:

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I have read and understood each question, and have answered all of the questions truthfully and to the best of my knowledge and ability. I understand that providing incorrect information can be dangerous to my health. I will not hold Endodontics, P.C. or any other employee of Endodontics, P.C. responsible for any errors and/or omissions that I may have made in the completion of this form. I understand that if any health changes occur during my treatment and completion of treatment at Endodintics, P.C. I am to report it to the dental office as soon as possible. I understand that upon completion of root canal therapy in this office,
I MUST RETURN TO MY GENERAL DENTIST FOR PERMANENT RESTORATION.

Signature of Patient or Guardian ______________________________ Date: ______________

Dentist Signature ______________________________ Date: ______________