Access Endodontics
Marat Tselnik, DDS
-PRACTICE LIMITED TO ENDODONTICS-

REFERRED BY: _____ TODAY'S DATE: _____

PATIENT
NAME _____ HOME PHONE _____
(LAST) (FIRST) (MIDDLE)

E-MAIL _____ CELL PHONE _____

HOME
ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

BIRTHDATE _____ #SSN _____

YOUR PLACE OF
EMPLOYMENT _____

YOUR OCCUPATION _____ BUSINESS PHONE _____

BILLING ADDRESS_____ PHONE _____
(STREET) (CITY) (STATE) (ZIP)

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT _____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE CO. _____ PHONE _____

ADDRESS _____

NAME OF INSURED _____SS# _____ID#_____

INSURED'D BIRTHDATE _____ GROUP # _____ UNION LOCAL # _____

SECONDARY INSURANCE CO. _____ PHONE _____

ADDRESS _____

NAME OF INSURED _____ SS# _____ID#_____

INSURED'D BIRTHDATE _____ GROUP # _____ UNION LOCAL # _____

I ACKOWLEDGE FULL RESPONSIBILITY FOR THE PAYMENT OF ANY FEES OR SERVICES AND AGREE TO PAY THEM, IN FULL, **AT OR BEFORE COMPLETION** OF TREATMENT, UNLESS OTHER ARRANGEMENTS ARE MADE WITH THE OFFICE MANAGER

-OVER FOR MEDICAL INFORMATION-

PATIENT MEDICAL HISTORY

NAME OF YOUR PHYSICIAN _____ PHONE _____

DATE OF THE LAST PHYSICAL EXAMINATION _____

List all medications you are taking, including daily aspirin and other over-the-counter drugs and herbal remedies:

_____

_____

_____

_____

Do you now have, OR have you ever had, any of the following? Please check the box

☐ Heart surgery, disease or attack	☐ Stroke	☐ Cancer or tumor	☐ High blood pressure
☐ Angina or chest pain	☐ Arthritis	☐ Epilepsy or seizure	☐ Hepatitis; Type ___
☐ Congenital heart disease	☐ Cold sores	☐ Thyroid disease	☐ AIDS or HIV
☐ Artificial heart valves	☐ Anemia	☐ Kidney disease	☐ Psychiatric or mental disease
☐ Pacemaker	☐ Diabetes	☐ Lung disease / TB	☐ Asthma
☐ Artificial joint replacement	☐ Osteoporosis	☐ Liver disease	☐ Blood or bleeding disorders
☐ Biphosphonates (Fosamax)	☐ Depression	☐ Glaucoma	☐ GERD / Ulcers / Colitis

YES	NO	
☐	☐	Are you currently undergoing medical treatment of any kind? If yes, please explain: _____
		_____
☐	☐	Have you ever had an **ALLERGIC** reaction to: latex, penicillin, codeine, aspirin, local anesthetic or any other substances? If yes, please list _____
☐	☐	Have you ever had prolonged bleeding from a cut, injury, or an extraction?
☐	☐	Do you smoke? How much? _____
☐	☐	Do you consume alcohol regularly? Drinks per day ____, per week ____, per month ____
☐	☐	Are you currently or have you within the last year used narcotics or recreational drugs?
☐	☐	Do you have a history of fainting?
☐	☐	Have you ever been a patient in our office before? If so, how long ago _____
☐	☐	Is there anything else about your medical history you think we should know? If Yes, explain: _____
		_____
		Women:
☐	☐	Are you pregnant? Month due: _____
☐	☐	Are you nursing?
☐	☐	Are you taking birth control pills?

IN CASE OF AN EMERGENCY, PLEASE CONTACT _____ AT _____
(PHONE)

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCUARATE TO THE BEST OF MY KNOWLEDGE

PATIENT / Guardian signature _____ **Date** _____

ACCESS ENDODONTICS
FINANCIAL POLICY

Thank you for choosing Access Endodontics as your dental health care specialist. Our main concern is you receive the proper and optimal treatment needed to improve and maintain your oral health. To avoid any possible misunderstandings regarding payments for services rendered, we are providing you with this statement of our financial policy. If you have any questions or concerns about our payment policies, please do not hesitate to ask our office staff.

1. For your convenience, our office accepts cash, personal checks, Visa, MasterCard, Care Credit or Discover

2. **Most dental insurance plans do not cover 100% of the cost of your treatment. Because of this, you will be asked to pay your deductible as well as your *estimated* portion of your charges the day services are rendered. There is a fee for consultation and any necessary diagnostic imaging at your initial visit.**

3. We will estimate as closely as possible your coverage, but until we actually receive payment from you insurance carrier, it is just that – an estimate. If we do not receive payment from your carrier within 60 days, the entire balance is due from you.

4. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.

5. **Please understand that we file and accept assignment of your insurance benefits as a courtesy to you. If your insurance denies coverage or does not pay *for any reason*, you are ultimately responsible for any and all charges incurred in our office.**

6. Account balances older than 60 days will be subject to finance charges of 1.5% per month, 18% per year, which will be added to your account. Balances older than 90 days will be subject to collection proceedings. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees.

7. Returned checks will be subject to additional collection fees of $35.00.

8. Please understand we reserve time in our schedule to provide services for you. A $50.00 fee will be applied to your account in the event of a cancellation of less than 24 hours.

Thank you for trusting us with your dental care. Any questions may be directed to our Business Manager. She can be reached at 503-635-3948 during our regular business hours.

ACKNOWLEDGEMENT OF NOTICE OF FINANCIAL POLICY

My signature certifies that I have read and understand Access Endodontics Financial Policy. I agree to abide by it, and will pay today with one of the following.

□ Cash □ MasterCard □ VISA □ Discover □ CareCredit □ Check

_____ _____

Signature (patient / guardian) **Date**

Access Endodontics

PRIVACY NOTICE ACKNOWLEDGEMENT

To Our Patients:

Federal Law requires that we provide you with a copy of our Privacy Notice.

The Privacy Notice explains how we may use and disclose health information about you. We ask that you sign this form for our records so that we may document your receipt of the Notice.

If you have questions about the Privacy Notice, please feel free to direct these to our Privacy Officer at any time. The name and contact number of the Privacy Officer is listed on your copy of the Privacy Notice.

Patient Name: _____ Date of Birth _____

Patient to complete this section

I have received a copy of the Privacy Notice for this organization on today's date.

Signed: _____ Date: _____

If patient is unable to acknowledge receipt, staff member providing notice to complete this section

The Privacy Notice was provided to

Patient Name: _____ On _____

The patient was unable to acknowledge receipt of the Privacy Notice for the following reason:

_____

_____

_____

Signed: _____

File this form in the patient's chart

Access Endodontics

AUTHORIZATION

Patient Name: _____ Date of Birth _____

PATIENT TO COMPLETE THE FOLLOWING:

I authorize _____ to use and/or help determine treatment for the following people:

_____

_____

This authorization is valid from _____ and expires on _____

I understand that I may refuse to sign this authorization.

I understand that you cannot condition provision of services or treatment based on whether or not I sign this authorization.

I understand that I have the right to revoke this authorization at any time by providing written notice to the organization. I also understand that the revocation is not applicable to information already disclosed while the authorization was in effect.

Signed: _____ Date: _____

Please file in patient chart and provide copy to patient at time of signature.

CONSENT FOR NON SURGICAL ENDODONTIC THERAPY

Patient Name: _____ Tooth#: _____
Please read this form and sign at the bottom.

1. I hereby give my consent for Dr. Tselnik to perform root canal treatment on the tooth or teeth listed above.

2. I understand that root canal treatment is a procedure to retain a tooth which may otherwise require extraction.

3. I understand that root canal treatment can have a very high degree of clinical success. However, as with Any branch of medicine or dentistry, no guarantee of successful treatment can be given or implied. Occasionally, a tooth which has had root canal treatment may require retreatment, a surgical procedure, or even extraction. Root canal cases started in other offices or retreatment cases may have a lower success rate even when the procedure is carried out under optimal conditions.

4. I understand that a permanent restoration will need to be placed after endodontic therapy. This might involve a post to retain the filling material, a buildup to fill in the hole made for access to the root canal, and potentially a crown which serves to protect the tooth from fracturing after the root canal. The endodontic treatment does not include these restorative procedures. I understand that it is my Responsibility to have an appropriate restoration placed following the root canal procedure

5. I understand that periodic recall examinations of the tooth to include radiographs are recommended to Evaluate the success of the treatment rendered. Compliance is the patient's responsibility.

6. Treatment will be performed in accordance with accepted methods of clinical practice. This will require the administration of local anesthetic agents and placement of a rubber dam. In addition, a number of radiographs will be taken as needed throughout the procedure.

7. Possible complications of treatment include, but are not limited to:
    - discomfort during or following treatment
    - infection or swelling
    - procedural difficulties such as the separation of instruments in the root canal space, or perforation of the crown or root while looking for the root canal space (associated with curved roots and calcifications of root space)
    - discovery of a fracture in the crown or root
    - additional unknown or unspecified problems, the explanation for and the responsibility of which cannot be given or assumed

8. I understand that I am free to withdraw my consent and discontinue treatment at any time; however, Complications such as bone destruction, infection and swelling, and/or pain, etc., may predictably occur if the root canal treatment is not completed.

9. The number of treatment visits required to complete the root canal varies with the complexity of each case. Generally, the routine cases can be completed in one or two appointments.

10. If at any time I have any questions about the treatment I am receiving, they will be promptly answered.

I have read the above information. I have had all my questions answered, and I consent to the above stated treatment.

_____ _____
Signature of patient or legal designate Date Signed