THE ROOT CANAL GUY

James Wolcott D. D. S

american association of endodontists

PATIENT INFORMATION

Name_____ _____
Last First Middle Marital Status

Home Address_____
Street City State Zip

Mailing Address_____
Street City State Zip

Home Phone #_____ Work Phone # _____ Mobile phone# _____

Social Security #_____ Birth Date:_____

Occupation:_____ Employer's Name:_____

Email: _____ _____
General Dentist

DENTAL INSURANCE INFORMATION

Insurance Co. Name:_____ Insurance Co. Phone #_____

Insurance Co. Address:_____ Policy Group #_____

Insured's Name:_____ Member ID # _____

Insured's Birth Date:_____ Insured's Employer:_____

EMERGENCY INFORMATION

Name of Emergency Contact:_____ Phone # ( )_____

METHOD OF PAYMENT

Which of the following methods of payment will you be using? (Fees must be paid **IN FULL** at the completion of treatment)

Method of Payment: □Cash □Visa □ MC □ AmEx □Discover

All information written is true and complete. If the account is placed with an attorney and/or collection agency, all reasonable costs and/or legal fees shall be borne by the undersigner. I further understand that a 1.5% finance charge will be added to any balance after the completion of planned treatment. If dental insurance applies, although this office files insurance claims as a courtesy to the patient, the insurance contract is between the patient and the insurance company. As we have no control over the insurance company's method of payment or amount of payment, any difference of payment is entirely the responsibility of the patient.

Signature_____ Date_____

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Medical History

Name_____

	YES	NO
1. Has there been any changes in your health within the past year.....	o	o
Please specify_____		
2. Are you under the care of a physician for a current problem?.....	o	o
Reason_____		
3. Have you been hospitalized within the past five years?.....	o	o
Reason_____		
4. Are you taking any medications or drugs?.....	o	o
Please specify_____		
5. Have you ever had any **ALLERGIC OR ADVERSE REACTIONS** to anesthetics, antibiotics, latex, nickel or other medications?.....	o	o
Please specify_____		
6. Have you received therapy for alcoholism or drug addiction during the past five years?.....	o	o

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

o High blood pressure	o Heart murmur(mvp)	o Asthma
o Joint prosthesis (hip,knee,etc)	o Congenital heart disease	o Sinus trouble
o Prosthetic heart valve	o Heart attack,strokes,by-pass	o Cancer
o Blood disorder (e.g. anemia)	o Rheumatic fever	o Diabetes
o Jaundice liver disease	o Epilepsy	o Hepatitis
o Severe Gag Reflex	o Stomach ulcers, colitis	o Thyroid Problems
o Difficulty getting numb	o Psychiatric treatment	o Dental Anxiety
o Temporalmandibular joint problems(TMJ)		

8. Have you ever had abnormal bleeding with previous extractions, surgery, or trauma?....	o	o
9. Have you ever required a blood transfusion?.....	o	o
Please explain_____		
10. Have you ever had surgery and/or radiation for tumor, growth, or other conditions?....	o	o
11. Have you ever been tested for HIV infection(AIDS)?.....	o	o
Results of test: Date_____ oPositive oNegative		
12. Date of last physical exam_____		
13. **Do you have any disease, condition, or problem not listed above?**.....	o	o
Please specify_____		
14. Are you **required** to take antibiotics prior to dental treatment?.....	o	o
15. Are you a smoker?.....	o	o

WOMEN:

16. Are you pregnant?.....	o	o
17. Are you nursing?.....	o	o
18. Are you taking birth control pills?.....	o	o

If yes, be advised that if you take antibiotics, an alternate method of birth control must be used.

All of the above information is true to the best of my knowledge.

_____ _____

Date Signature of patient*

*All signatures must be by a parent or guardian if patient is under the age of 18.

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Financial Consent Form

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage that I may have is based on a contract between my insurance company and me, my spouse and/or my employer. The dentist is not a party to this contract. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatment procedures and/or diagnostic methods provided to me.

As a courtesy to our patients, our office will help file insurance claims. However, we are not responsible for what the insurance company does or does not pay. I acknowledge that I will remain liable for any and all amounts not paid by the insurance company for any reason (including but not limited to the insurance company declining coverage after initially approving it) or if the insurance company fails for any reason to reimburse the dentist within 61 days after being billed by the dentist. If this office is able to accept your insurance company's assignment, it does not absolve the patient of full responsibility for the full charges of the treatment rendered. Dental claims are submitted promptly after treatment is rendered, in most cases electronically on the same date of service, and if not paid by the patient's insurance company by the 61st day after treatment, the patient will be billed in full.

I understand that the balance is subject to a finance charge of 1.5% annually, if not paid within 30 days of statement date and I may be referred to a collection company or attorney. In the event this occurs, I understand that I will be liable for collection cost. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I, _____ hereby authorize payment of the dental plan benefits payable directly to James Wolcott D.D.S. I understand this does not absolve me from full responsibility for the full charges of the treatment rendered. Once the insurance company has paid, if there is a remaining balance, a statement will be mailed and payment in full will be due upon receipt of the statement.

We require that you give our office 24 hours notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $100.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Signature: _____ Date: _____

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Patient Consent/Acknowledgement Form

By signing below, you consent to the use and disclosure of your protected health information by Dr. James Wolcott, our staff and our business associates (your general dentist, other specialists and your insurance) for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice. We will post any revised Notice in the office.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree on these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use of disclosure of your protected health information, but this must be done in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information (PHI).

This form is also used to obtain acknowledgment of receipt of **OUR NOTICE** of privacy practices or to document our good faith effort to obtain that acknowledgement.

I have reviewed, understand and agree to the consent of the notice of privacy.

Print Name _____ Date_____

Signature _____

If refused, please specify the exact reason why the patient chose not to sign the consent/acknowledgement of notice of privacy. All forms are for educational use only and do not constitute legal advice. All forms are subject to changes in the federal law and applicable state laws. Seek legal advice before use.

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Name: _____

1. Is your tooth **presently? A) Sensitive B) Uncomfortable C) Painful D) No Pain**

2. How bad is the pain level **now**, on a scale from 0(**no pain**) to 10(**severe pain**)? **0-1-2-3-4-5-6-7-8-9-10**

3. When did the pain start? _____

4. How long a period of time has it been sensitive/uncomfortable/painful?
   Hours:___ Days:___ Weeks:___ Months:___ Years:___

5. Can you describe the pain? **Dull, Throbbing, Pounding, Sharp, Stabbing, Other**_____

6. What makes your tooth hurt? **Cold, Hot, Biting, Chewing, Pressure, Lying down, Other**_____

7. Does your tooth ever hurt by itself or only when it's stimulated? **Itself/Stimulated**

8. Is the pain continuous or intermittent(on/off)? **Continuous/Intermittent**

9. What makes your tooth feel better? **Cold, Hot, Biting, Chewing, Pressure, Lying down,**

   Pain medication (Ibuprofen or Tylenol), Other_____

10. Has any recent dental work been completed in the area where there is pain? **YES NO**

    If yes, what and when?_____

11. Have you ever had a root canal before? **YES NO** By who **General Dentist/Root Canal Specialist**?

    When? _____

Signature:_____ Date:_____

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