PATIENT INFORMATION

Patient Name:_____
How would you like our staff to address you?_____
Address:_____
City:_____ State:_____ Zip:_____ Phone:_____
Email Address:_____ Cell Phone:_____
Social Security Number:_____Date of Birth:_____
Employer:_____
Employer's Address:_____
City:_____ State:_____ Zip:_____ Phone:_____
What is the name of your referring dentist?_____
What is the name of your physician?_____
Person to contact for emergency?_____ Phone:_____

DENTAL INSURANCE INFORMATION

Primary
Insured's Name:_____ Relation to Patient:_____
Social Security Number:_____Date of Birth:_____
Employer's Name/Address:_____
Insurance Co Name/Address:_____
_____ Phone:_____Group #:_____

Secondary
Insured's Name:_____ Relation to Patient:_____
Social Security Number:_____Date of Birth:_____
Employer's Name/Address:_____
Insurance Co Name/Address:_____
_____ Phone:_____Group #:_____

RESPONSIBLE PARTY INFORMATION

(For minors or dependents)
Name:_____ Relation to Patient:_____
Address:_____
City:_____ State:_____ Zip:_____ Phone:_____
Social Security Number:_____ Date of Birth:_____
Employer's Name/Address:_____
City:_____ State:_____ Zip:_____ Phone:_____

I authorize the release of any dental information in order to process insurance claims, and authorize payment of dental benefits to Ocean County Endodontics, LLC for professional services rendered. I agree that I am responsible for all dental fees that my insurance does not cover and that my insurance claim is filed as a courtesy to me.

Signature (must be 18 or older or parent/guardian)_____

OCEAN COUNTY ENDODONTICS, LLC
381 LAKEHURST RD, TOMS RIVER, NJ 08755

Have you ever had or have you now: (please check ALL boxes to the right of the items listed)

Check each item	Y	N	Check each item	Y	N	Check each item	Y	N
Epilepsy or Seizures			Bruise or Bleed easily			Kidney problems		
Fainting or Dizziness			Heart problems or Angina			Venereal disease		
Nervousness			Hypertension			Diabetes		
Stroke			Rheumatic fever			Thyroid disease		
Cold Sores (Herpes)			Heart Murmur			HIV+		
Persistent Cough			Mitral valve prolapse			Arthritis		
Emphysema			Congenital heart lesions			Painful joints (incl. jaw)		
Tuberculosis/PPD+			Heart surgery			Prosthetic joint(s)		
Asthma			Prosthetic heart valve(s)			Hives		
Hay Fever			Pacemaker			Steroid medication(s)		
Sinus problems			Blood transfusion			Drug Addiction		
Anemia			Liver disease			Alcoholism		
Sickle cell disease			Yellow jaundice			Unexplained weight chg.		
G-6PD deficiency			Hepatitis-type:			Cancer/radiation		
Hemophilia			Ulcers			Glaucoma		

- Are you taking any blood thinners (i.e. Coumadin, Plavix)?_____
- Are you taking Bisphosphonates (i.e. Boniva)?_____
- Have you ever been told that you should not donate blood?_____
- Have you ever been told that you need antibiotics before dental treatment?_____
- Do you have a disease, condition or problem not listed above?_____
  If yes, please describe: _____
- What medications are you currently taking? _____
  _____
- Are you presently under the care of a physician? **YES** **NO**
  If yes, please describe:_____
- History of hospitalization(s):_____
  (including Cancer treatment)_____
- Any allergies? (Incl. rubber/latex)_____
- Are you in an alcoholism recovery program?_____ How long?_____
- Are you taking any herbal supplements? (If yes, please describe)_____
  _____
- **Females:** Are you taking any birth control pills?_____
  Are you or might you be pregnant?(Estimated delivery date)_____
  Are you breast-feeding at the present time?_____

Patient Signature_____ Date _____	Doctor Signature_____ Date _____

Ocean County Endodontics, LLC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT:

Name:_____

Address:_____

Telephone:_____**E-mail:**_____

Social Security Number:_____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Ocean County Endodontics, LLC, Office Mgr., 381 Lakehurst Road, Toms River, NJ 08755 (732)341-6800

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I,_____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I give my consent to your use and disclosure of my protected health information to carry our treatment, payment activities, and health care operations.

Signature:_____**Date:**_____

If this Consent is signed by the personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____

INFORMED CONSENT FOR ENDODONTIC TREATMENT

The goal of root canal treatment is to save a tooth that might otherwise require extraction. Although root canal treatment has a very high success rate, as with all medical and dental procedures, it is a procedure whose results cannot be guaranteed. Further, root canal treatment is performed to correct an apparent problem and occasionally, an unapparent, undiagnosed or hidden problem arises.

This procedure will not prevent future tooth decay, tooth fracture or gum disease, and occasionally a tooth that has had root canal treatment may require re-treatment, endodontic surgery or tooth extraction.

RISKS: ***ARE <u>UNLIKELY-</u> BUT MAY OCCUR. THEY MIGHT INCLUDE BUT ARE NOT LIMITED TO:***

- ***A.*** Instrument separation in the canal.
- ***B.*** Perforations (extra openings) of the canal with instruments.
- ***C.*** Blocked root canals that cannot be ideally completed.
- ***D.*** Incomplete healing.
- ***E.*** Post-operative infection requiring additional treatment or the use of antibiotics.
- ***F.*** Tooth and/or root fracture that may require extraction.
- ***G.*** Fracture, chipping, or loosening of existing tooth, crown or porcelain veneers.
- ***H.*** Post-treatment discomfort.
- ***I.*** Temporary or permanent numbness.
- ***J.*** Change in the bite or jaw joint difficulty (TMJ problems or TMD).
- ***K.*** Medical problems may occur if I do not have the root canal completed.
- ***L.*** Reactions to anesthetics, chemicals or medications.

OTHER TREATMENT CHOICES:

The following other treatment options might be possible:

- **A.** No treatment at all.
- **B.** Waiting for more definitive development of symptoms.
- **C.** Extraction: to be replaced with either a denture, a bridge, an implant or do nothing.

After the completion of the root canal procedure, you will be referred back to your restorative dentist for the permanent restoration (filling, crown, cap). Failure to have the tooth properly restored in a timely manner (generally within 30 days) significantly increases the possibility of failure of the root canal procedure or tooth fracture.

I have had an opportunity to ask questions and am satisfied with the answers that I have received. I consent to the procedure.

PATIENT'S SIGNATURE_____
DOCTOR'S SIGNATURE_____
DATE:_____