Curt A. Warren, D.D.S. – Endodontics, P.C.

CONFIDENTIAL HEALTH HISTORY – PATIENT INFORMATION FORM

Patient Name: _____ Home Phone: _____
Address: _____ Work Phone: _____ Ext: _____
City/State/Zip: _____ Cell Phone: _____

Sex: M F Date of Birth: _____ Patient Social Security #: _____

How did you hear about our office? _____
Who is your dentist? _____
Have you had previous endodontic treatment? (Root Canal Therapy) _____

Rate your overall health: Good _____ Fair _____ Poor _____
Are you currently under the care of a physician? Yes_____ No _____
If yes, please explain: _____
Who is your medical doctor: _____
If female, are you pregnant? Yes _____ No _____ What month? _____
Have you ever had trouble with prolonged bleeding? _____
Have you ever had an allergic reaction to a drug, medicine or latex? _____
Is there any other information that we should know about your health? _____
_____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT:

High Blood Pressure	Smoke	Epilepsy / Fainting	Heart Disease
Respiratory / Asthma	Cancer	Glaucoma / Visual	Heart Murmur / Defect
Rheumatic Fever	Radiation / Chemotherapy	Mental / Neural	Pacemaker
Hypertension / Circulatory	Tuberculosis	Tumor / Neoplasms	Heart Attack / Stroke
Immunocompromised	Fatigue	Alcoholism / Addiction	Irregular Heart Beat
Anemia / Bleeding	Swelling	Infectious Diseases	Prosthetic Implant
Diabetes / Kidney	Thyroid / Hormonal	Venereal Disease	Any Transplant
Herpes	Ulcers / Digestive	Psychiatric Care	Joint Replacement
Hypoglycemia	Migraine / Headaches	TMJ	Arthritis

Please list all current medications: _____
_____

I THE UNDERSIGNED, BEING THE PATIENT OR THE PARENT OR THE GUARDIAN OF THE ABOVE MINOR PATIENT, CONSENT AFTER CONSULTATION TO THE PERFORMING OF WHATEVER PROCEDURE MAY BE DETERMINED NECESSARY BY THE DOCTOR. I AUTHORIZE AND REQUEST THE ADMINISTRATION OF SUCH DRUGS AND/OR ANESTHETICS AS DEEMED ADVISABLE BY THE DOCTOR. I ALSO UNDERSTAND THAT UPON COMPLETION OF THE ROOT CANAL THERAPY IN THIS OFFICE I WILL BE REFERRED TO MY DENTIST FOR A RESTORATION SUCH AS AN AMALGAM OR COMPOSITE FILLING OR CROWN. I CERTIFY THE ABOVE HEALTH HISTORY TO BE CORRECT. I AUTHORIZE RELEASE OF MY TREATMENT RECORD.

_____ _____
Signature Date

PATIENT INFORMATION:

Marital Status: married single widowed divorced

Place of employment: _____

Employer phone number: _____

INSURANCE COVERAGE:

self spouse dependent

SUBSCRIBER INFORMATION, IF OTHER THAN SELF:

Name: _____ Date of birth: _____

Social security number: _____ Employer: _____

EMERGENCY CONTACT:

Name: _____ Phone number: _____

Relationship to patient: _____ Alternative number: _____

AUTHORIZATION TO RELEASE INFORMATION:

Curt A. Warren, D.D.S. – Endodontics, P.C. is authorized to provide any insurance company(s), claim administrator(s), and consulting health care professionals, information concerning health care, advice, treatment, or supplies provided.

_____ _____

Signature Date

FINANCIAL RESPONSIBILITY AGREEMENT:

In consideration of treatment rendered to the above named patient, I accept full financial responsibility. An insurance claim will be submitted electronically at completion of treatment as a convenience to the patient. **PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED**. Payment arrangements, if needed, **MUST be made prior to treatment**. I further agree that if this account is turned over to an attorney or collection agency, I will be responsible for all collections costs, court costs, interest of 21%, and reasonable attorney fees.

_____ (initial) **I understand that the full estimated payment is due by completion of treatment.**

_____ _____

Signature Date

CURT A. WARREN, D.D.S. – ENDODONTICS, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

_____ _____

Signature *Date*

Financial Policy for Patients with Dental Insurance

We must inform you of this statement or disclaimer that is always stated to us:

THIS IS NOT A GUARANTEE OF PAYMENT

The amount quoted to the patient is just an estimate based on the information provided to us. Some insurance policies have maximum allowable amounts or fee schedules. These amounts are sometimes not disclosed to the provider, due to the insurance company's standard operating procedures. ***Any difference between what insurance pays and our fees is the patient's responsibility.***

The patient is responsible to be aware if their insurance plan stipulates a waiting period or frequency for any services.

At times, the information above is not available immediately to the office; therefore it is the responsibility of the patient to understand the terms and conditions of their policy and coverage. We will file your insurance and attempt to provide an educated estimate as a courtesy to our patients.

Despite all efforts to provide the patient with as much information as possible, the insurance company reserves the right to request any overpayments directly from the provider who, then in turn must request the over payment from the patient.

By signing this, I fully understand I am responsible for any amount insurance does not pay.

_____ _____

Name Date

COVID-19 Pandemic Dental Treatment Consent Form

I, _____, knowingly and willingly consent to have 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 limits 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 form minutes to sometimes hours, which can transmit the COVID-19 virus.

*_____ I understand that due to 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.

*_____ 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, or Sore throat

*_____ 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 apart for a period of 14 days to anyone who has, and this is not possible with dentistry.

*_____ I verify that I have not traveled outside the United States in the past 14 days to countries that have been affected by the COVID-19.

*_____ I verify that I have not traveled domestically within the United States by commercial airline, bus or train within the past 14 days.

Signature _____

Date _____

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.

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 written authorization, we cannot use or disclose your health information for any reason except for 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 heath 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, 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.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victims of other crimes.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and their national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (you must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $.15 for each page, $13.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in the format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we, or our business associates, disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that w communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or locations, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy right, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative locations, you may complain to us using the contact information list at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

CONTACT INFORMATION

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