SILBERMAN ENDODONTICS

Patient Information:

Date: ___________

Who is filling up this information? Self / Guardian: Name: ____________________________

Relationship to patient: ____________________________

Patient Last Name: ____________________ Patient First Name: _____________________

Date of Birth: _____/______/________ SS: ______________________ Sex: M F

Address: ____

City: _____________________________ State: ________________ Zip Code: ___________

Cell Number: __________________________ Work Phone #: ____________________________

E-mail: _______________________________ Referring Dr: ______________________________

Person to contact in case of emergency: ____

Relationship to patient: _______________________ Phone #: _____________________

Person responsible for this Account: ____

Relationship to patient: _______________________ Phone #: _____________________

Do you have Dental Insurance? YES NO Insurance Company: _______________________

PLEASE LIST THE PEOPLE WITH WHOM WE CAN DISCUSS YOUR INFORMATION (This information may include, but is not limited to dental appointments, treatment, medical history, insurance and/or billing)

Name: ____

Relationship to patient: _______________________ Phone #: _____________________

Name: ____

Relationship to patient: _______________________ Phone #: _____________________

____ Date: _________________

Patient /Guardian Signature

SILBERMAN ENDODONTICS

Health History:

Patient Name: ______________________________

		ALLERGIES:	Medications:
○ Sinus Problems ○ Low Blood Pressure ○ High Blood Pressure ○ Respiratory/ Asthma ○ Rheumatic fever ○ Lung Disease ○ Immunocompromised ○ Anemia/Bleeding ○ Diabetes ○ Herpes ○ Thyroid/Hormonal ○ Hypoglycemia ○ Smoking ○ Lupus ○ Cancer ○ Radiation/Chemotherapy ○ Tuberculosis ○ Liver Disease ○ Hepatitis ○ HIV/AIDS ○ Drug Dependency	○ Ulcers/Digestive ○ Migraine/Headache ○ Epilepsy/Fainting ○ Glaucoma/Visual ○ Mental/Neural ○ Tumor/Neoplasm ○ Alcoholism/Addiction ○ Infectious Disease ○ Venereal Disease ○ Psychiatric Care ○ TMJ ○ Heart Disease ○ Heart Murmur/Defect ○ Pacemaker ○ Heart Attack/Stroke ○ Irregular Heartbeat ○ Prosthetic Implant ○ Any Transplant ○ Joint Replacement ○ Arthritis ○ Kidney Disease	○ Penicillin ○ Erythromycin ○ Clindamycin ○ Aspirin ○ Tylenol ○ Ibuprofen ○ Codeine ○ Percocet ○ Valium/ Tranquil ○ Local Anesthesia ○ Acrylic ○ Bleach ○ Iodine ○ Metal ○ Latex ○ Seafood ○ Other:	○ No Medications ○ If yes, Explain: **NEED TO PREMED?** ○ Yes ○ No **HISTORY OF SINUS PROBLEMS?** ○ Yes ○ No

Do you have any diseases, syndromes or other medical problems not mentioned above?
If Yes explain: ____

Dental History:

Are you having pain? _________________________________
Chief Complaint: ______________________________________

Consultation:	Chronology:	Quality:	Affected by:	Visual Exam
○ Symptomatic ○ Asymptomatic **Location:** ○ Upper Right ○ Lower Right ○ Upper Left ○ Lower Left ○ Referred ○ Radiating	○ Constant ○ Intermittent ○ Occasional ○ Lingering ○ Referred	○ Sharp ○ Dull ○ Throbbing ○ Steady ○ Enlarging ○ Spontaneous	○ Hot ○ Cold ○ Sweets ○ Chewing ○ Biting ○ Head Position ○ Palpation	○ Recent Crown ○ Recent Filling ○ Previous Root Canal ○ Swelling ○ Discoloration ○ Caries

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It I my responsibility to inform the dental office of any changes in my medical status.

____ ________________
Signature Date

SILBERMAN ENDODONTICS

Patient Name: ___________________________ Date: ___________

PROTECTED HEALTH INFORMATION CONSENT:

Introduction:

Silberman Endodontics, Inc. must obtain your consent before using or disclosing protected health information, as required by recent federal regulation. "Protected Health Information" includes your demographics information as well as information regarding your health condition and related treatment. Such information may be used by Silberman Endodontics Inc, its staff and others outside our offices that are involved in your case treatment, payment, and support the operations of our office.

Your rights:

You may revoke your consent in writing, unless Silberman Endodontics, Inc. has taken action in relation to such consent. You are entitled to request restrictions on the use and disclosure of your health information for purposes of providing your treatment, and Silberman Endodontics, Inc. is bound to such restrictions to which we have agreed to.

Silberman Endodontics, Inc. may provide you with a notice of privacy practices at your request, and you may review that notice prior to signing this consent

CONSENT:

I, ____ (your name) hereby consent to the use and disclosure of my protected health information by Silberman Endodontics, Inc., its staff, and others outside its office for the purposes of treatment, payments, and to support the operations of Silberman Endodontics, Inc. practice, I understand that I may revoke such consent in writing at any time.

____ Date: _________________

Patient /Guardian Signature

PATIENT FINANCIAL AGREEMENT & RELEASE OF INFORMATION

The following is a statement of the Practice's financial policies, which you must read and agree to prior to any treatment.

1. PAYMENT. Payment of any unmet deductible, co-insurance, co-payment, and any charges not covered by insurance is expected at the time of your visit. We accept cash, debit card, and major credit cards. In addition, we may have additional financing options available to you on or after your initial date of service. **Please note that payments made by credit card will incur a 3% surcharge.**

2. INSURANCE, DEDUCTIBLES, CO-PAYMENTS, AND CO-INSURANCE

- It is your responsibility to confirm which treatments or procedures are covered and/or paid by insurance (including, but not limited to, any applicable exclusions, deductibles, and annual or lifetime maximums) & any referrals required by your insurance.
- As a courtesy, we will file your insurance claim for you; however, please remember that insurance is NOT a guarantee of payment. In order to bill your insurance and to meet filing guidelines, we require a copy of your insurance card and a photo ID.
- We can only approximate the percentage covered by each plan. Payment of the ESTIMATED portion as well as your co-payment is due at time of service.
- Any estimate of insurance coverage may differ from what your insurance carrier ultimately pays. You will be responsible for any charge that insurance determines to be not covered.
- **NOTE: If your doctor has recommended General Anesthesia, this does NOT mean your insurance will consider this to be a "Medically Necessary" procedure and pay for this service
- As the parent or guardian accompanying a minor, you are financially responsible for all charges, whether or not paid by insurance.
- In situations of divorce, separation, court orders, etc., the adult who signs in a minor child on the day of treatment accepts financial responsibility for payment.
- Non-covered procedures will not be filed to insurance.
- Private pay/uninsured patients: (i) you must pay in full at time of service, and (ii) you hereby acknowledge receipt of a Good Faith Estimate as required by 45 C.F.R. §149.610 by signing below.

3. BILLING AND COLLECTION.

- Payment is due as stated on any billing statement mailed, emailed or otherwise delivered to you. If we do not receive payment within fifteen (15) days of the due date, your account shall be past-due.
- Interest at the maximum rate amount allowed by law will be charged on all past due accounts.
- Past due accounts may be placed with a collection agency or attorney for collection.
- In addition to the charges for services and treatment received, you agree to be responsible for and to pay all costs and expenses incurred in the collection of amounts past due on your account including, but not limited to, collection agency fees (either 33.33% of the amount due or the maximum amount allowed by applicable law), reasonable attorney's fees and expenses, collection expenses, and court costs. If your account is turned over to collections, you hereby accept any such fees and costs as a legal and lawful debt and agree to paid said fees, including any and all resulting fees and costs. You hereby waive your right of exemption under any applicable laws.
- If your account is turned over for collections, you will no longer be able to receive services from the Practice until your delinquency is cured.

4. CONSENT TO CONTACT. The Practice and anyone contacting you on our behalf may contact you for any purpose and in any manner permitted by law. You also expressly consent to be contacted by the Practice, and anyone contacting you on our behalf, for any purpose, including billing, collection, or other account or service-related purpose, at any telephone number or physical or electronic address where you may be reached, including any wireless telephone number. We and/or anyone contacting you on our behalf may contact you in any way, such as calling, texting, emailing, sending mobile application push notifications, or using any other method of communication permitted by law. You agree that the Practice, and anyone contacting you on our behalf, may communicate with you in any manner, including through the use of an artificial or pre-recorded voice message or an automatic telephone dialing system. We may contact you on a mobile, wireless, or similar device, even if you are charged for it.

I have read the financial policies above, and my signature below indicates my agreement to these policies and acceptance of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for any services provided to me, I assume financial responsibility and will pay all such charges in full.

I hereby authorize the Practice to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the Practice all insurance benefits otherwise payable to me for the Practice's services.

______________________	____/____/______
Patient Name	Patient DOB
______________________	______________________
Patient or Responsible Party Signature	Date
______________________	______________________
Printed Name of Responsible Party (if applicable)	Relationship to Patient (if applicable)

(Version 08.2024)

CONSENT FOR ROOT CANAL THERAPY, ENDODONTIC SURGERY, ANESTHETICS AND MEDICATION

You will be required to sign this form prior to the initiation of treatment. Although endodontic (root canal) therapy has a high degree of success, results cannot be guaranteed. On occasion, a tooth which has had root canal therapy may require retreatment, surgery or even extraction. While serious complications with endodontic (root canal) therapy are uncommon, we want you as our patient to be informed about the various procedures involved and have your consent before starting any treatment. Endodontic therapy is performed to retain a tooth that otherwise might require extraction. This is accomplished by root canal therapy or endodontic surgery. Accurate and complete disclosure of the patient's current and past medical information, including allergy history, is needed for proper diagnosis and treatment. The following describes possible risks involved with endodontic therapy and other treatment choices.

Risks: Include, but are not limited to, complications resulting from the use of dental instruments and supplies, drugs, sedation, medicines, analgesics and injections. These complications may include, without limitation, swelling, sensitivity, bleeding, pain, infection, temporary or permanent numbness and tingling sensation in the lip, tongue, cheek, gums and teeth (very infrequent complications from injections), changes in occlusion (bite), jaw muscle cramps and spasms, TMJ difficulty, loosening of teeth, referred pain to ear, neck or head, nausea, vomiting, allergic reaction, delayed healing, sinus perforation, and treatment failure.

Risks Specific to Endodontic Therapy: Include, but are not limited to, the possibility of instruments separating or breaking within the root canal, perforations (extra openings) of the crown or root of a tooth or sinus, damage to bridges, dentures, crowns, existing fillings or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals, and cracked teeth. During treatment, complications could arise which make treatment impossible or which may require dental surgery. These complications may include blocked canals due to fillings or prior treatment, natural calcifications, separated instruments, curved root, periodontal (gum) disease and splits or fractures of the teeth. Treatment will require a series of diagnostic radiographs and, in some cases, may require more than one visit to your endodontist.

Medications: On occasion, medications or drugs may be prescribed by your endodontist. Medications used and/or prescribed for discomfort and/or sedation may cause drowsiness or lack of awareness and coordination, which can be increased by the use of alcohol, tranquilizers, sedatives or other drugs. We advise that you do not operate a motor vehicle or any hazardous device while taking or under the influence of such medications. In addition, certain medications may cause allergic reactions, such as hives or intestinal discomfort. If any of these problems occur, please call your endodontist or your endodontist's office and staff immediately.

Other Treatment Options: There are times when a minor surgical procedure may be indicated or when the tooth may not be amenable to endodontic treatment at all. Other treatment choices include, without limitation, no treatment, a waiting period for more definitive symptoms to develop, or tooth extraction. Risks involved in those choices might include, but are not limited to, pain, infection, swelling, loss of teeth, and infection to other areas.

It is the patient's responsibility to report any changes in his/her medical history to his/her endodontist.

As a specialty practice, this office performs only endodontic therapy and associated surgery. Following treatment, the tooth may be brittle and subject to fracture. A restoration (filling), crown and/or post and core will be necessary to restore the tooth, and your general dentist will perform these procedures. It is important that you follow up with your general dentist promptly following endodontic treatment for permanent restoration and care. Failure to do so within 30 days of your endodontic treatment could cause complications, such as infection of the treated tooth leading to the need for further endodontic treatment or extraction of the tooth.

Consent: By signing below, I acknowledge that I fully understand the statements and information in this consent form.

____________________________________	____________________________________
Patient Name (Printed)	Patient DOB
____________________________________	____________________________________
Patient or Responsible Party Signature	Date
____________________________________	____________________________________
Printed Name of Responsible Party (if applicable)	Relationship to Patient (if applicable)