WELCOME

CARMEL VALLEY
Justin N. Naylor, DDS & Anthony L. Korbar II, DMD
ENDODONTICS

1 ABOUT YOU

Today's Date: _____/_____/_____ File #:_____

Patient Name: _____
LAST FIRST MI

What you prefer to be called: _____

SS#:_____ ☐Male ☐Female

Birth date: _____/_____/_____ Age: _____

Mailing Address: _____

_____
CITY STATE ZIP

Phone #: (_____) _____

E-mail: _____

Referred By: _____

Employer: _____

Dental Insurance Carrier: _____

Subscriber ID Number: _____

2 IN EVENT OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone #: _____

Work Phone #: _____

Who is your Medical Doctor? _____

M.D.'s Phone #: _____

3 FINANCIAL INFO

ABOUT FINANCIAL ARRANGEMENTS, THIRD PARTY PAYMENT AND DENTAL INSURANCE

Payment is due at the time services are rendered. We accept cash, checks, credit cards, and bank debit cards. We will be glad to help process your insurance claim for your reimbursement. Provided you give us the proper information, the dental insurance form will be ready by the time treatment is completed. Your understanding about the following information is important to us:

- Your insurance or third party contract arrangement is between you, your employer and the insurance company. We may not be a contracted provider for your specific plan.
- Not all services are covered benefits in all contracts. Insurance companies select certain services they will or will not cover. Promptness in processing your claim varies from one insurance company to another; it may take 30-60 days to process your dental claim.
- Perhaps the most misunderstood part of your coverage is known as the usual, customary and reasonable (UCR) charges. The UCR is the maximum fee that your policy will cover. This dollar figure varies with each dental policy and is determined in large part by the amount of coverage purchased by your employer. Stated simply, the lower the UCR, the more out-of-pocket expense. For this reason, we encourage you to check with your insurance company for details.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While filing of insurance claim forms is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered.

If you have any questions about the above information, please do not hesitate to ask us. We are here to help.

Patient's signature _____ **Date**_____/_____/_____

☐Adult Patient ☐Parent or Guardian ☐Spouse

****Please provide information for the person financially responsible, if other than the patient:**

☐ Not Applicable

Name: _____ Relationship to patient:_____

Billing Address (if different than Section #1): _____

PLEASE CONTINUE

4 MEDICAL HISTORY

Are you currently taking any medication, vitamins, supplements or drugs?……Yes No

If yes, please list name and dosage: _____

Are you aware of any **allergic (or adverse)** reaction to any medication or substance?……Yes No

If yes, please list name and reaction: _____

Have you been a patient in the hospital during the past five years?……Yes No

If yes, please explain: _____

Please indicate any health conditions you currently have or have had in the past:

High Blood Pressure……	Yes	No	Diabetes……	Yes	No
High Cholesterol……	Yes	No	Metabolic Disorder……	Yes	No
Heart (surgery, attack, etc)……	Yes	No	Thyroid Disease……	Yes	No
Chest Pain……	Yes	No	Acid Reflux or Ulcers……	Yes	No
Congenital Heart Disease……	Yes	No	Asthma……	Yes	No
Artificial Heart Valve……	Yes	No	Bronchitis or Emphysema……	Yes	No
Pacemaker or Defibrillator……	Yes	No	Seasonal Allergies……	Yes	No
Stroke……	Yes	No	Headaches (migraine, etc)……	Yes	No
Artificial Joints (hip, knee, etc)……	Yes	No	Immune (HIV, AIDS, etc)……	Yes	No
Arthritis……	Yes	No	Neurological (fibromyalgia, etc)……	Yes	No
Rheumatism……	Yes	No	Psychological……	Yes	No
Auto-immune Disease……	Yes	No	Depression or Anxiety……	Yes	No
Kidney (disease, failure, etc)……	Yes	No	Epilepsy or Seizures……	Yes	No
Liver (hepatitis, jaundice, etc)……	Yes	No	Cancer……	Yes	No
Bleeding or Clotting Disorder……	Yes	No	Radiation/Chemotherapy……	Yes	No
Anemia (Sickle cell, etc)……	Yes	No	Latex Sensitivity……	Yes	No

Any conditions NOT listed above: _____

Women: Are you: **Pregnant?** Yes, Months_____ / No **Nursing?** Yes / No **Taking birth control pills?** Yes / No

5 CONSENT FOR ENDODONTIC THERAPY

Root canal therapy is a commonly performed and safe procedure to save a tooth which might otherwise need to be removed. We want our patients well informed about the procedure and its risks as well as alternative treatment options.

RISKS: Risks include, but are not limited to, pain, facial swelling or bruising, bleeding, infection, reaction to anesthetics, jaw and muscle pain and spasms, temperomandibular joint (TMJ) problems, jaw fracture, numbness or tingling of the lip, chin, tongue, gums, cheeks or teeth (which is generally temporary but can in rare instances be permanent), sinus perforation or inflammation, allergic reactions, injury to the mouth or eyes, alterations of taste, changes in your bite. When serious, any of these may require loss of teeth and hospitalization. Complications can occur which may make a successful outcome (healing) less likely or impossible, or which may require dental surgery to correct. These may include blockages of the canals due to fillings or prior treatment, natural blockages (calcifications), broken instruments, severely curved or narrow root canals, periodontal (gum) defects requiring follow-up periodontal therapy, or fractured teeth.

PRESCRIBED MEDICATIONS: Allergic reactions, nausea, vomiting, diarrhea, or gastrointestinal problems may require additional medical treatment to resolve. Pain medications can cause drowsiness or lack of awareness or coordination, which may be influenced by the use of alcohol, tranquilizers, sedatives and other drugs. You should not operate a motor vehicle or dangerous device while taking these medications. Prescription drugs may interact or interfere with other drugs you are already taking.

OTHER TREATMENT CHOICES: As an alternative, you may decide to have the tooth extracted, wait for more definitive symptoms to develop, or choose no treatment. Extraction and no treatment also pose risks, which may include pain, swelling, spread of infection, and loss of teeth.

CONSENT: I acknowledge that I have read the above carefully and consent to the procedures deemed necessary or advisable by the doctors of Carmel Valley Endodontics. I understand that root canal therapy is not always successful and on occasion a tooth, which has had root canal therapy, may require re-treatment, surgery or extraction. I also understand that upon completion of treatment, I must return to my general dentist for permanent restoration of my tooth.

Patient's Name (please print) _____ **Tooth #:**_____

Patient's Signature _____ **Date**_____/_____/_____

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse

Provider's Signature _____ **Date**_____/_____/_____

6 ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) aims to protect the confidentiality of your healthcare information. Typically, only those involved with your treatment (ie. your general dentist) or payment for services rendered (ie. your insurance company) will be provided with this information.

I have had the opportunity to review a copy of this office's Notice of Privacy Practices.

(PERSONAL COPY PROVIDED UPON REQUEST AT FRONT DESK)

_____ [Please Print Name]

_____ [Signature]

_____ [Date]

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

Personal Representative's name _____

Relationship to Patient _____

****You May Refuse to Sign This Acknowledgement****

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

7 CELL PHONE AND EMAIL CONSENT

I consent to the dental practice using my cell phone number to call □ and/or text □ regarding appointments, treatment, insurance and my account. I understand I can withdraw my consent at any time.

Patient Signature: _____

I consent to receiving from the dental practice email communications regarding treatment, insurance and my account. I understand I can withdraw my consent at any time

Patient Signature: _____

8 RECEIPT OF POST OPERATIVE INSTRUCTIONS

I have received and understand the written Post Operative Instructions

Patient Initials: _____