PRECISION ENDODONTICS

Patient Name: _____ DOB: _____
Address: _____
Street City, State Zip
Phone number: _____
Home Mobile Work
Email address: _____
Preferred method of contact: (please circle one) Home Mobile Work e-mail

Responsible Party:
Name: _____ DOB: _____SSN: _____
Address: _____
Street City, State Zip
Phone number: _____
Home Mobile Work
Email address: _____
Preferred method of contact: (please circle one) Home Mobile Work e-mail

INSURANCE:
Subsciber Name: _____ DOB: _____
Relationship to patient: _____
Employer: _____
Insurance Company: _____ Phone number: _____
Claims address: _____
Member ID#/SSN: _____Group Number: _____

Additional insurance:
Subsciber Name: _____ DOB: _____
Relationship to patient: _____
Employer: _____
Insurance Company: _____ Phone number: _____
Claims address: _____
Member ID#/SSN: _____Group Number: _____

Missed Appointment (s) and Cancellations:
In order to provide the best services to our patients, we require at least a 24-hour notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in cancelling or missing your appointment. A charge may be assessed for multiple missed, short notice or cancelled appointments. Multiple failed appointments may result in being dismissed from the dental practice. We reserve the right to charge for appointment cancellations or broken appointments without 24-hour notice. The fee for broken appointments is $50 per occurrence. The fee may be waived for unforeseeable circumstances at the discretion of Precision Endodontics, LLC.

By signing below I certify that all information provided is correct or to the best of my knowledge to be true.

X_____
Signature of patient or legal guardian Date

HEALTH HISTORY UPDATE Today's Date: _____

Patient Name: _____**DOB**: _____

Physician:_____
Name Address Phone Number

Are you currently under medical care? ___ No ___Yes
If yes, for what reason? _____
Have you ever had any serious illness or operation? ___ No ___ Yes
If yes, describe: _____
Do you smoke? ___ No ___Yes If yes, how many packs per day: _____
Do you chew tobacco? ___ No ___Yes If yes, how much & how often?: _____
Do you use recreational drugs? ___No ___Yes
How often do you drink alcohol? _____
Do you take an antibiotic routinely before a dental appointment? ___No ___Yes
If yes, why? _____

Have you had any allergic reaction to:

Local Anesthetics (like Novocain) ___No ___Yes, _____
Penicillin or other antibiotics? ___No ___Yes, _____
Sulfa Drugs ___No ___Yes, _____
Sedatives ___No ___Yes, _____
Iodine ___No ___Yes
Aspirin ___No ___Yes
Other (not listed):_____

Women only, are you:

Pregnant ___No ___Yes If yes, due date: _____
Nursing ___No ___Yes
Taking birth control pills ___No ___Yes

Please list below any medications you currently take, including vitamins and over-the counter medications: (if you have a list available, we can copy it for you).

1.	4.
2.	5.
3.	6.

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV	☐ Allergic to Penicllin	☐ Allergic to: _____	☐ Allergic to Codeine	☐ Dental PreMed required
☐ Back Problem	☐ Blood disease	☐ Heart Attack	☐ Stroke	☐ Diabetes
☐ Chemical dependency	☐ Alcohol dependency	☐ Head/Neck growths	☐ Epilepsy or seizures	☐ Cancer of: _____
☐ Chemotherapy	☐ Blood Disorder	☐ Arthritis	☐ Joint Replacement	☐ Excessive Bleeding
☐ Hay Fever	☐ Anemia	☐ Dizziness	☐ Fainting	☐ Glaucoma
☐ Asthma	☐ Head Injury	☐ Heart disease	☐ Heart Murmur	☐ Hepatitis
☐ High or Low Blood Pressure	☐ Juandice	☐ Kidney disease	☐ Liver disease	☐ Mental or Nervous disorder
☐ Allergic to Latex	☐ Lung disease	☐ Cardiac pacemaker	☐ Radiation treatment	☐ Respiratory problems
☐ Rheumatic Fever	☐ Sinus Problems	☐ Tuberculosis Active or latent	☐ Tumors	☐ Ulcers
☐ Venereal disease	☐ Bisphosphonate use (Osteoporosis or cancer drugs)	☐ Blood Transfusion	☐ Herpes/Fever blisters	☐ Other (not listed):

Do you have any health problems that need further clarification? • Yes • No
If yes, please explain:

_____

Patient Signature:_____ Date:_____

PRECISION
ENDODONTICS

FINANCIAL POLICIES

The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to treatment.
Please Note: Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express and CareCredit.
Please note: Additional fees will be applied for returned checks.

- Returned check fee is $35.
- All account balances over 90 days are subject to a $15.00 billing fee.
- Accounts 90 days past due will be sent to our collection agency.

-As a courtesy to you, we will help you process your dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. The estimated amount given is only an estimate and not a guarantee of payment from your insurance until the claim is processed.
-All charges you incur are your responsibility, regardless of your insurance coverage.
-Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
-The patient/responsible party agrees to pay the deductible, co-payment and co-insurance, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, Discover, American Express and CareCredit at the time services are provided and/or after insurance finalizes any claims submitted.
-We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. We will file appeals to your insurance if it is deemed necessary but will not continue filing after 90 days. If the insurance denies payment after 3 requests and an appeals letter, the charges will be your responsibility.
-Minors accompanied by the parent or legal guardian: The parent or legal guardian accompanying the minor, who has consented to treatment is the responsible party for full payment at time of service. All minors must be accompanied by their legal guardian for any treatment provided by our practice.

Consent:
I have read, understand and agree to the above terms and conditions. I authorize my insurance company, if any, to pay my dental benefits directly to Precision Endodontics, LLC. I understand that responsibility
for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

_____
Signed by Patient /Guardian Date

_____
Patient /Guardian name PRINTED

Notice of Privacy Practices
Consent for Use and Disclosure of Health Information

Print Patient Name: _____ DOB: _____

PLEAE 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 healthcare 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 healthcare, 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 is available upon request. 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; 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:
Privacy Officer: Amanda Dickason, Office Manager
Telephone: (913) 346-3636 Fax: (913) 346-3636
Address: 2541 S. 4th St., Leavenworth, KS 66048

Right to Revoke: You will 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 of 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.

Signature: 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 am giving my consent to your use and disclosure of my protected health information to carry out treatment payment activities and health care operations.
You have the right to authorize others to have access to your medical information. If you wish not to have information shared, please do not fill out the information chart below.

Please list any persons you wish to have access to your account: (All areas of account will be accessible, unless documented below).

Name of authorized person(s):	Relationship:	Phone number:
1.		
2.		
3.		

Signature of Patient/Legal Guardian Date