Chanhassen Endodontics

-Patient Registration-

Patient Information

Last Name: _____ First Name: _____ MI: _____

Address: _____ City, State, Zip: _____

Date of Birth: _____ SSN:_____

Phone #: _____ E-mail: _____

Who may we thank for referring you? _____

_____

Insurance Information

Insurance Company: _____

Group #: _____ Subscriber #: _____ Insurance Phone #: _____

If the subscriber/insured is NOT the patient, please provide the information of the subscriber:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ SSN:_____

Phone #: _____

To the best of my knowledge, all of the preceding information is correct.

Signature of Patient/Guardian: _____ Date: _____

Chanhassen Endodontics
-Financial Policy-

Patients *with* Dental Insurance
We are non-participating providers with most insurances. Although, patients are still able to utilize their benefits. We will submit to your dental insurance on your behalf. We typically collect ~55%, for most insurances, the day of treatment depending on your remaining yearly benefits and your insurance carrier. For Delta Dental patients it is 100% fees up front due to payment going to you directly. *Benefits quoted to you are only an estimate provided by the patient coordinator.* We will do our best to get the coverage you deserve, the benefits belong to the patient and it is also up to you to ensure that you are receiving appropriate reimbursement under the terms of your plan. There is no guarantee of benefits from the insurance company until a claim is received and processed. If the insurance pays more then expected we will mail you and refund you a check. If the insurance company pays less, we will mail a bill with your remaining balance. After your balance is 90 days past due the remaining balance will go to collections and/or you are subject to late fees.

Patients *without* Dental Insurance
We will collect full payment day of treatment. We do apply a 5% discount for all patients with no insurance. We accept cash, checks, debit and credit cards. It is your responsibility to pay the full fee of services upon the day of treatment. You could opt in for the payment plan option as well and pay through care credit, just ask the front desk how to get it set up.

Payment Plan Option:
CareCredit:
We offer a payment plan option through CareCredit of 6 months with no interest. Applicants can apply online or via the phone and be approved for financing the same day. If approved, 100% of fees will be submitted to CareCredit. The applicant will be billed directly by CareCredit. If you would like more information on CareCredit, please ask out patient care coordinators for more information.

I have read and agreed to the financial policy.

Signature of Patient/Guardian: _____ Date: _____

Chanhassen Endodontics
-Health History-

Patient Name: _____ Date of Birth: _____

An accurate and thorough health history allows us to provide our patients with safe and quality care. Your answers are for our records and are considered confidential.

Please Circle 'YES' or 'NO' for the following questions:

YES NO Do you consider yourself in good health?
YES NO Have there been any major changes in your health in the past year?
YES NO Have you ever been instructed to take pre-medications before dental treatment?

Do you have any of the following conditions? Circle which one upon answering YES

YES NO Damaged heart valves, artificial valves, pacemaker, artificial arteries or grafts
YES NO History of rheumatic fever or scarlet fever
YES NO Congenital heart defect or murmur
YES NO Cardiovascular disease, heart attack, hypertension, stroke or cardiac insufficiency
YES NO Artificial joints or surgically placed prosthesis, including hip or knee joints. If so when?
YES NO Low blood pressure or fainting
YES NO High Blood Pressure
YES NO Seizures or epilepsy
YES NO Diabetes or blood sugar problems. A1C:_____
YES NO Liver disease, history of jaundice or Hepatitis
YES NO Kidney disease or stomach ulcers
YES NO Tuberculosis or Asthma
YES NO Alcoholism, drug use or dependence
YES NO Psychotherapy or nervous conditions
YES NO History of bleeding problems, blood disorders or Anemia
YES NO Immunocompromised including HIV, ARC, or AIDS
YES NO Have you ever had treatment for cancer including x-ray treatment or chemotherapy? If so, when?
YES NO Do you have any diseases, conditions or problems other than those listed above?
If Yes, please provide more details _____

_____

_____

Women:

YES NO Are you pregnant or possibly pregnant at this time
YES NO Are you currently a nursing mother

(Continues on Backside)

Do you have any allergies or adverse reaction to any of the following medications? Circle which one upon answering YES

YES NO Latex allergy
YES NO Penicillin or other antibiotics Name:_____
YES NO Aspirin or Ibuprofen
YES NO Sulfa drugs or Iodine
YES NO Codeine or other narcotic medications Name:_____
YES NO Valium, sedatives, or sleeping pills
YES NO Have you or any blood relative had any adverse reactions to local or general anesthetic?
YES NO Other
If Yes, please provide more details _____

_____

_____

Are you currently taking any of the following medications? Circle which one upon answering YES

YES NO Antibiotics, what are you taking them for, and how long?_____
YES NO Anticoagulants (blood thinners)-If yes, please list the name/names below
YES NO Blood pressure medications- If Yes, please list the name_____
YES NO Steroids- If yes, please list the name/names below
YES NO Tranquilizers or Antihistamines-If yes, please list the name/names below
YES NO Aspirin, Ibuprofen, Naproxen (Aleve) or Tylenol
YES NO Insulin, Metformin or other blood sugar altering medications
YES NO Digitalis, Nitroglycerin or other heart medications
YES NO Oral contraceptives

Please list ALL current medications and dosages: _____

_____

_____

_____

_____

_____

I understand that withholding any information about my health could seriously jeopardize my safety and the safety of others. Therefore I have reviewed this health history carefully and have answered all questions to the best of my knowledge and it is my responsibility to notify my doctor of any health changes at future appointments.

Signature of Patient/Guardian: _____ Date: _____

Chanhassen Endodontics
-HIPAA Compliance Consent-

Our notice of privacy practices provided information about how we may use or disclose your protected health information.

The notice contains a patients rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor the agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected Health information may be disclosed or used for treatment, payment or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? **YES** **NO**

May we leave a message on your answering machine at home or on your cell phone? **YES** **NO**

May we discuss your medical condition with any member of your family? **YES** **NO**

If YES, please name the members allowed:

_____

_____

This consent was signed by:_____

(PRINT NAME PLEASE)

Signature:_____ Date:_____