## PATIENT INTRODUCTION
**(Please print with black or blue ink)**

**PATIENT**

Mr/Mrs/Miss/Ms/Dr _____

Last First Middle

_____

Street Address City State Zip

_____

Phone number Date of Birth Social Security Number (*for insurance) Driver's License Number/State (*ck payment)

_____

Employer's Name & Address Occupation Business Phone

**Family General Dentist** _____

**PARENT/GUARDIAN**_____

Name (If patient is a minor)

_____

Social Security Number (If patient is a minor) Date of Birth (If patient is a minor)

## DENTAL INSURANCE

**Primary Dental Insurance Company** _____ **Group #** _____

**Address** _____ **800#** _____

**Employee Name** _____ **Relationship to patient** _____

**(If different from patient)**

**SS#** _____ **Date of Birth** _____ **Work phone** _____

**Employer** _____ **Address** _____

I understand that even though I have insurance coverage that may apply to dental care, I am responsible for the payment of treatment services. I understand that I am responsible for any portion of the treatment charge that my insurance company does not pay and that I will be refunded any overpayment. I further agree that a finance charge in the amount of 1.5% will be added to my account on the 1st day of each month for the unpaid balance that exists on the last day of the prior month. A $20 fee will be charged for any returned check. If my payments are delinquent at any time and if the services of a collection agency are necessary, I agree to share the total fees to be paid to the agency, or to the attorney, and one-half of the total fees may be added to my account. There will be a $45 charge for cancelled appointments unless 48 hours notice is given. I authorize the release of any requested clinical records for the sole purpose of reimbursement.

## PREFERRED METOD OF PAYMENT

At the beginning of treatment I plan to pay my fee or if applicable my insurance co-payment by the following method:

____ Cash or Money Order ****Driver's License Number/State (Required if paying by check)**: _____
____ Personal Check (No out-of-state checks, please)
____ Visa, MasterCard, American Express, Discover, or Care Credit

**PLEASE SIGN BELOW**

_____

*Signature of Patient/Parent/Guardian* *Date*

# Confidential Medical History

Date: _____/_____/_____

Mr/Mrs/Miss/Ms/Dr _____
(Last) (First) (Middle)

Present Complaint (why were you referred):

_____

_____

New Present Complaint: _____ Date: ____/____/____

New Present Complaint: _____ Date: ____/____/____

1. Physician (**Medical** Doctor):_____ Phone: (____) _____-_____

   Address: _____

2. Have you recently been under the care of a physician for anything other than regular check-ups? _____ **YES/NO**

   _____

3. Have you ever had any **serious** illnesses? Details: _____ **YES/NO**

   _____

4. Are you **allergic** to or do you have any ill effects from any medications or to latex? _____ **YES/NO**

   Please List: _____

5. Are you taking **ANY** prescriptions or over-the-counter drugs at this time? Please List: _____ **YES/NO**

   _____

6. Do you have any bleeding problem? Details: _____ **YES/NO**

7. **Women:** Are you pregnant? How many months? _____ **YES/NO**
   Are you nursing? _____ **YES/NO**

8. Do you use tobacco? _____ **YES/NO**

9. Please circle any of the following which you have or have had (if Hepatitis, please circle B ,C or D):

| | | | | |
|---|---|---|---|---|
| Heart Murmur | Heart Surgery | Diabetes | Blood Transfusion | Asthma |
| Mitral Valve Prolapse | Stroke | Kidney Disease | Herpes | Allergies |
| Rheumatic Fever | High Blood Pressure | Thyroid Disease | AIDS/AIDS Antibody | Sinus Trouble |
| Dizzy Spells | Pacemaker | Liver Disease | HIV/HTLV-III Positive | Arthritis/Joint Pain |
| Seizures | Tuberculosis | Hepatitis B C D | Anemia | Glaucoma |

Heart Trouble/Heart Attack Explain: _____

Cancer Explain: _____

Radiation Therapy/Chemotherapy Explain: _____

10. Do you have any artificial joints? Date Placed: _____ Type of Joint: _____ **YES/NO**

11. Do you have anything else that you would like the doctor to know? Details: _____ **YES/NO**

    _____

**Signature:** _____ **Date:** _____/_____/_____
(Patient/Parent/Guardian)

GARY P PASCOE DMD PC
ENDODONTICS

2696 S. Colorado Blvd. Suite #410 * Denver, CO 80222 * 303-789-2354

## CONSENT AND INFORMATION FORM

Endodontic therapy (root canal treatment) is a procedure to retain a tooth which may otherwise require extraction. Although root canal therapy has a high degree of clinical success, it is a biological procedure and cannot be guaranteed.

I, the undersigned , understand the following:

1) In order to make an accurate diagnosis and examine the tooth internally for fractures, pathology and decay, we will take several angled radiographs (x-rays) in our office. These radiographs help to determine the correct course of treatment.

2) Root canal treatment may be recommended to me; failure to follow this recommendation may result in tooth loss, bone destruction due to an abscess and/or possible systemic (involving the whole body) infection.

3) Certain percentages (5-10%) of root canals fail and they may require retreatment, periapical surgery or even extraction.

4) There are certain risks involved in the administration of analgesics (pain medicine), antibiotics, and anesthetics. Occasionally, dental anesthesia may result in persistent numbness that may be temporary or permanent. Prescribed pain medications may cause drowsiness or lack of coordination. It is not advisable to drink alcohol, use other drugs or to operate machinery during the use of these medications. For women who are prescribed antibiotics and are taking birth control pills, it is advised they use an alternative form of birth control during the complete menstrual cycle for which the antibiotic is taken. Antibiotics may decrease the efficacy of birth control pills.

5) Durning treatment of the tooth, an instrument may break and lodge permanently in the tooth or an instrument may perforate the root wall. Although this rarely occurs, such an occurrence may cause failure of the root canal, require additional surgical corrective treatment or loss of tooth.

6) Complications to root canal therapy also included blocked canals (the tiny channels in the roots that are cleaned during therapy) due to fillings, prior treatment or natural calcified obstructions; as well as curved roots, splits or fractures of teeth. These complications may compromise the end result of therapy and result in a higher treatment failure rate.

7) When making access, (an opening) through an existing crown or placing a rubber dam clamp, damage could occur that would require a new crown following endodontic therapy.

8) Post-operative discomfort, swelling, and/or restricted jaw opening may persist for several days.

9) Temporary fillings are usually placed in the tooth after root canal treatment. I understand that I need to return promptly to my family dentist for the placement of the permanent restoration.

10) I understand that I have other treatment choices that include no treatment at all or having the tooth removed.

Date _____ Signature _____
(patients/parent/guardian)

Witness _____

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# Financial Policy

Our goal is to provide Endodontic treatment to our patients at a high level of professional care in a friendly, personalized and competent manner. We are pleased to discuss our professional fees with you at any time. Please feel free to ask any question regarding our financial policy as well as your proposed dental treatment.

**Payment is expected at the time of service**. We accept Visa, MasterCard, Discover, American Express, as well as cash and personal, in-state checks.
****There will be a finance charge in the amount of 1.5% added to the account on the 1st day of each month for the unpaid balance that exists on the last day of the prior month.**

**Insurance -**

Our office staff will be glad to assist you in obtaining your maximum insurance benefits.

**You must realize, however, that:**

a. Your dental benefit program is a contract between you, your employer, and the insurance company. **We are not a party to that contract.**
b. Not **all** dental services are a covered benefit in all contracts.
c. We will estimate the **approximate** insurance liability and ask that you pay your portions at the time services are rendered.
d. **You are responsible to us for all fees for services rendered to you.**

It is very helpful for you to become familiar with the terms of your dental insurance. This will enable you to know what services are covered benefits under your plan and what percentages they pay. We will also assist you in this matter. We appreciate your cooperation and thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

**I understand that I am responsible for all costs of dental evaluation and/or treatment regardless of what my insurance carrier may or may not pay. (If after 60 days we have not received payment, the balance will be your responsibility.)**

**(The signature below will also serve as a signature on file for assignment of insurance benefits.)**

Patient Signature: _____

Date: _____

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# ACKNOWLEDGEMENT OF PRIVACY PRACTICES (HIPAA)

We are required by applicable federal and state law to maintain the privacy of your health information. These Health Information Privacy Policies and Procedures implement our obligations to protect the privacy of individually identifiable health information that we create, receive, or maintain as a healthcare provider.

I acknowledge that I am aware of this office's privacy policy and I may request a copy of the privacy policy at the front desk is I wish.

***Please list any individual(s) and relationship that you give permission to receive information regarding your treatment and/or finances relating to our office:**

_____

_____

_____

Signature

_____

Date

**General Dental Treatment Consent Covid-19 Pandemic**

1. I knowingly and willingly consent to dental treatment at Gary Pascoe D.M.D. by Dr. Gary Pascoe and any designated associates and employees during the COVID-19 pandemic.
2. I understand that the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms yet are highly contagious. It is impossible to determine who has COVID-19 and who does not given the the characteristics of and variants of the virus.
3. Risk of transmission: I understand that due to the frequency of visits of other dental care patients, 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, even though standard precautions are being observed.
4. I am unaware of being a possible carrier or infected: I confirm that I have not tested positive for COVID-19 in the last 30 days and that I am not presenting with any of the following symptoms of COVID-19:
    - Fever of 100.5 degrees or higher
    - Shortness of breath
    - Dry cough
    - Runny nose
    - Sore throat
    - Diminished sense of taste or smell
    - Vomiting or diarrhea
5. If I have tested positive for COVID-19 in the last 30 days, I confirm I am now symptom free and have now tested negative.
6. Contact with infected: I confirm that I have not knowingly been in close contact defined as 6 feet or less for a duration of 15 minutes or more with someone who has tested positive for COVID-19 in the last 14 days, or anyone that has had the above stated symptoms in the last 14 days.
7. I have been fully vaccinated Y N
8. I have had a booster shot Y N

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the risk of contracting COVID-19 from the dental office and dental procedures. I do voluntarily assume any and all reasonable medical/dental risk including the substantial and significant risk of serious harm, if any, which may be associated with any phase of my treatment as a result of the COVID-19 pandemic.

_____ _____ _____

printed name signature of patient date