Patient Registration

Patient Name: ____

Address: ____

Home Phone: ____________________ Work Phone: ____________________

Cell Phone: _____________________ Email: _____________________________

Date of Birth: _____________________ SSN: ___________________________

Employer Name & Address: ____

Dental Insurance Company: ____

Insurance Policy Holder Name: ____

Policy Holder Date of Birth: ______________________ ID # _________________

Medical History

1. Do you have unhealed injuries or inflamed areas, growths, or sore spots in or around your mouth? □ Yes □ No (If yes, please explain)

   ____

2. Has there been any change in your general health within the past year? □ Yes □ No (If yes, please explain)

   ____

3. Are you under the care of a physician for a current problem? □ Yes □ No (If yes, please explain)

   ____

4. Have you been hospitalized within the past 5 years? □ Yes □ No (If yes, please explain)

   ____

5. Have you received therapy for alcoholism or drug addiction during the past 5 years? □ Yes □ No (If yes, please explain)

   ____

6. Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetics, antibiotics or medications? □ Yes □ No (If yes, please explain)

   ____

7. Is there any condition concerning your health that the doctor should be told? □ Yes □ No (If yes, please explain)

   ____

8. Do you wish to speak to the doctor privately about anything? □ Yes □ No
9. Have you had abnormal bleeding with previous extractions, surgery, or trauma? □ Yes □ No (If yes, please explain)

   ____

10. Have you ever required a blood transfusion? □ Yes □ No (If yes, please explain)

    ____

11. Have you ever had radiation for any condition? □ Yes □ No (If yes, please explain)

    ____

12. Have you ever tested positively for HIV infection or AIDS? If so state the date diagnosed and treating Dr. □ Yes □ No (If yes, please explain)

    ____

13. Before a dental appointment are you required to take premedication? □ Yes □ No (If yes, please explain)

    ____

14. Do you have, or have you had any of the following:

□ High blood pressure	□ Sinus trouble
□ Heart murmur or prolapsed valve	□ Thyroid problems
□ Joint prosthesis (hip, knee, etc)	□ Diabetes
□ Rheumatic fever or rheumatic heart disease	□ Stomach ulcers, colitis
□ Congenital heart disease	□ Hepatitis, jaundice, liver disease

□ Cardiovascular disease: heart attack, stroke or bypass	□ Kidney problems
□ Prosthetic heart valve	□ Psychiatric treatment
□ Blood disorder (e.g., anemia)	□ Fainting spells or seizures
□ Venereal disease	□ Epilepsy
□ Asthma	□ Cancer
□ Allergy to latex	□ Temporomadibular joint problems
□ Low blood pressure	□ Low blood sugar
□ Chest pain, angina	□ Dialysis
□ Swollen ankles, arthritis or joint disease	□ Irregular heart beat
□ Cardiac pacemaker	□ Contagious diseases
□ Heart surgery	□ Bronchitis, chronic cough
□ Delay in healing	□ Hay fever or sinus problems
□ Tuberculosis	□ Problems with the immune system
□ Emphysema	□ Difficult breathing or other lung trouble
□ X-Ray treatment or chemotherapy	□ Chronic fatigue or night sweats
□ On a diet	□ History of drug abuse
□ History of alcohol abuse	□ Wear contact lenses
□ Eye disease or glaucoma	□ Bruise easily
□ Infectious mononucleosis	□ Gallbladder trouble

15. Are you taking any herbal medicine? □ Yes □ No (If yes, please explain)

    ____

16. Have you ever taken the “fen-phen” diet? □ Yes □ No (If yes, please explain)

    ____

17. Do you have any diseases, condition, or problem not listed above? □ Yes □ No (If yes, please explain)

    ____

18. Are you taking bisphosphonates now or have you ever taken them in the past? (Fosamax) □ Yes □ No (If yes, please explain)

    ____

19. Women only:

□ Taking birth control pills?	□ Nursing?
□ Possibility of pregnancy?	Due Date:

20. Date of last physical exam: ________________________
21. Physician Name and Phone: ______________________________________
22. Specialist Name and Phone: ______________________________________
23. Are you taking any medication or drugs? □ Yes □ No (If yes, please explain)

    ____
24. Emergency Contact Name and Phone Number:

    ____

Pain History

1. Have you experienced pain in this tooth at any time in the past?
   □ Yes □ No
2. Are you in pain now (or have you ever had pain with this tooth)?
   □ Yes □ No
3. If you are in pain now, how long have you been in pain?

   ____
4. Did this pain either keep you awake or awaken you last night?

   ____
5. Can you locate the tooth that is causing the pain? □ Yes □ No
6. Does the pain radiate to other parts of your jaw or down your neck and shoulders? □ Yes □ No
7. Is the pain spontaneous or does it always require some stimulus to become painful?

   ____
8. Do you feel swollen now? □ Yes □ No
9. Has there been a history of prior swelling? □ Yes □ No
10. Are you running a fever? □ Yes □ No

11. How would you rate the severity of your pain today? 1= Very Slight and 10= Unbearable

    ____

12. Do you have lingering pain (more than a few seconds)? □ Yes □ No
13. Please check the frequency and nature of the pain that most closely describes your discomfort. Check all options that apply to your case:

□ Sharp	□ Dull	□ Radiating
□ Throbbing	□ Migrating	□ Constant
□ Aching	□ Intermittent	□ Momentary
□ Gnawing	□ Variable	□ Enlarging to other areas
□ Shooting	□ Tingling	□ Itching
□ Burning	□ Only when chewing or biting	

14. Is the tooth sensitive to temperature?

□ More to hot than cold	□ More to cold than hot
□ Equally to hot and cold	□ Neither
□ Not sure	□ Neither, but there is a history of temperature sensitivity in the past

15. What relieves the pain?

□ Nothing	□ Cold	□ Hot	□ Darvon/Darvocets	□ Tylenol
□ Non-biting	□ Aspirin	□ Codeine	□ NSAIDS	
□ Antibiotics	□ Vicodin	□ Massage	□ Advil/Alleve	□ Other

16. If you don’t touch the tooth or bite on it, does it still hurt?

□ Yes	□ No	□ Only if I bite in a certain way
□ Sometimes	□ Not now, but it has in the past	

17. What increases the pain?

□ Touching	□ Biting	□ Cold	□ Hot
□ Cold Air	□ Lying down	□ Eating	□ Flossing
□ Nothing	□ Sweets	□ Pressing on gums	

18. What is the course of the pain?

□ Increasing	□ Decreasing	□ Constant
□ Variable	□ None now	

19. Has there been any recent restorative work done on this area? □ Yes □ No
20. Prior to this appointment has endodontic treatment been started by any doctor? □ Yes □ No

21. Have you had recent periodontal (gum) surgery in the area or a tooth cleaning? □ Yes □ No
22. Have you ever had an endodontic surgery (apico) on this tooth? □ Yes □ No
23. Are you numb now? (been given anesthesia earlier today) □ Yes □ No □ Slightly
24. Have you taken any antibiotics for this problem? If so, how long? ____
25. Have you taken any pain killers for this problem? If so, what did you take and for how long? ____
26. Did you explicitly request this referral? □ Yes □ No
27. Did your Doctor/Dentist recommend this referral? □ Yes □ No

Office Financial Policy

If we **only** provide Endodontic Evaluation (Limited Evaluation, Consultation):

This consists of an examination and testing, discussing the likelihood of maintaining the tooth and treatment options available to you. Payment is due at the time of service.

If we provide Treatment:

Those without dental insurance: Fifty percent of the total will be required when we begin treatment and the balance due upon completion of treatment. If we complete treatment in a single visit, payment is due at the time of service.

Those with dental insurance: We will estimate the portion your insurance is going to pay. Since this varies for each individual, usually 25 - 75% of the cost of the procedure is required at the time of service. We will bill your insurance for you. *Please keep in mind however, insurance companies routinely indicate that coverage verification does not guarantee payment.*

▶ If your insurance pays **more** than the estimated amount, a refund check from this office will be mailed within 1 month from the date payment is received in this office. We usually batch them at the end of the month.

▶ If your insurance pays **less** than the estimated amount, you will receive a statement from this office. We usually do not send monthly statements so prompt attention is greatly appreciated! NOTE: *If your insurance company does not reimburse us after 2 submissions, you will be responsible for the remainder of the balance since we were unable to collect from them. Balances over 30 days are subject to interest charges.*

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (08/03/15), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your

incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.___ for each page, $___ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may

complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Consent for Endodontic Therapy

Please review the following consent form. You will be required to sign this form prior to the initiation of treatment. Your signature does not commit you to any treatment.

Occasionally, medication will be prescribed by . Medications prescribed for discomfort and/or sedation may cause drowsiness, which can be increased by the use of alcohol or other drugs. We advise that you do not operate a motor vehicle or any hazardous device while taking such medications. In addition, certain medications may cause allergic reactions, such as hives or intestinal discomfort. If any of these problems occur, call immediately. It is the patient's responsibility to report any changes in his/her medical history to .

I understand the root canal therapy is a procedure that retains a tooth, which may otherwise require extraction. As a specialty practice, this office performs only endodontic therapy and associated surgery. Although root canal therapy has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth, which has had root canal therapy, may require retreatment, surgery, or even extraction. 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. During endodontic treatment, there is the possibility of instrument separation within the root canals, perforations (extra openings), damage to bridges, existing fillings, crowns or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals, and fractured teeth. Also, 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 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.

All of my questions have been answered by , and I fully understand the above statements in this consent form.

Consent for Surgery

This document reflects my consent to the endodontic procedures indicated and any other procedures deemed necessary or advisable as a corollary to the planned endodontic surgery performed by Dr. Andrew N. Yamamoto, Dr Timothy W Jue and Dr Joelle A Tavitian and surgical assistant(s). I agree to the use of local anesthesia, depending upon Dr. Yamamoto, Dr Jue, or Dr Tavitian's judgment.

I am aware that complications of microsurgery and anesthesia may include the following: pain, swelling, trismus (restricted jaw opening), infection, bleeding, sinus involvement, numbness or tingling of the lip, gum or tongue, which rarely are protracted, and even more rarely, are permanent. I understand that it is my responsibility to report any symptoms to Dr. Yamamoto immediately.

Occasionally, medication will be prescribed by your endodontist. Medications prescribed for discomfort and/or sedation may cause drowsiness, which can be increased by the use of alcohol or other drugs. We advise that you do not operate a motor vehicle or any hazardous device while taking such medications. In addition, certain medications may cause allergic reactions, such as hives or intestinal discomfort. If any of these problems occur, call Dr. Yamamoto immediately. It is the patient's responsibility to report any changes in his/her medical history to Dr. Yamamoto.

It has been explained to me, and I understand, that a perfect result from surgery is not guaranteed. I have been given the opportunity to question Dr. Yamamoto, Dr. Jue, or Dr. Lazarou concerning the nature of the treatment, the inherent risks of the procedure(s), and the alternative(s) to such treatment(s). This consent form does not encompass the entire discussion I had with Dr. Yamamoto, Dr. Jue, or Dr. Lazarou regarding his/her proposed treatment(s).

I hereby authorize Dr. Andrew N. Yamamoto, Dr Timothy W Jue, or Dr. Laurie Lazarou and surgical assistant(s) to provide treatment for the condition(s) described below:
____

____

Furthermore, I give Dr. Andrew N. Yamamoto, Dr Timothy W Jue, Dr. Laurie Lazarou my permission to record, videotape and/or take photos of my procedure. These photographs may be used for purposes of documentation, education and/or teaching.

I have read and agree the terms set above.

Patient Signature: ____

Date: _______________________________