Endodontic Specialists

Jessica L. Barr, DDS, MS, PA
DIPLOMATE, American Board of Endodontics
David L. Spencer, DDS, MS, PLLC
Abby Yavorek, DMD, MS, PLLC
DIPLOMATE, American Board of Endodontics

Patient Name____Date of Birth_____________________

Address_________________________________City___________________State_______Zip__________

Phone Numbers: Home__________________ Work __________________Mobile___________________

Current or previous occupation _____________________ Retired? Y / N Employer _________________

Spouse / Partner's Name____________________ Date of Birth__________ Employer _________________

Emergency Contact_____________________Phone Number______________Relationship_____________

Who, if anyone, may we speak to regarding your endodontic care?__________________________________

Please check all that apply:

☐ I am or have been under the care of a medical doctor within the last two years

Reason for medical care _______________________________Physician_____________________

☐ I have an allergy to any of the following (please list reactions)

- ☐ Latex — Reaction:_______________________
- ☐ Bleach — Reaction:_______________________
- ☐ Drugs or Medications:
  1. _____________________ Reaction:_______________________
  2. _____________________ Reaction:_______________________
  3. _____________________ Reaction:_______________________

☐ I am currently pregnant (If yes, how many weeks): _________________

☐ A physician has recommended I usually take antibiotics before routine dental appointments

☐ I currently or previously have taken bisphosphonate medications or other medications that can affect bone (i.e., Actonel, Fosamax, XGeva, or Prolia) within the past 12 years

☐ I have had radiation therapy to the head/neck region (Reason/Area): __________________________

Please list all medications you are currently taking with dosages:

____
____
____
____

☐ I am attaching a separate list of medications or medical concerns/procedures (we are happy to make a copy if needed)

Note: Antibiotics may render birth control pills ineffective. An alternative form of birth control is advised.
Recreational drugs/alcohol may interact with medications used during the dental procedure. Please inform your doctor if this is a consideration.

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Please check any of the following you have currently or have had in the past

☐ Heart Failure	☐ Shortness of Breath	☐ HIV Positive/AIDS	☐ Long-term Steroid Use
☐ Heart Disease/Attack	☐ Emphysema	☐ Hepatitis A	☐ Kidney Problems
☐ Chest Pains	☐ Cough	☐ Hepatitis B/C	☐ Thyroid Disease
☐ High Blood Pressure	☐ Tuberculosis	☐ Liver Disease	☐ Stomach Ulcers
☐ Heart Murmur	☐ Asthma (Rescue Inhaler: Y/N)	☐ Sexually Transmitted Dis.	☐ Osteoporosis
☐ Mitral Valve Prolapse	☐ Seasonal Allergies	☐ Cold Sore/Blister	☐ Jaw/TMJ Issues
☐ Congenital Heart Problem	☐ Fainting/Dizziness	☐ Bleeding Disorder	☐ Arthritis
☐ Artificial Heart Valve	☐ Tobacco Use	☐ Blood Transfusion	☐ Artificial Joint
☐ Heart Pacemaker	☐ Drug Use/Addiction	☐ Sickle Cell Disorder	Date:________
☐ Stroke	☐ Diabetes	☐ Cancer/Tumor	☐ Psychiatric Care
☐ Epilepsy/Seizures	☐ Glaucoma	☐ Radiation Therapy	

Who is your general dentist? ____

Are you under the care of other dental specialists such as a periodontist (gums), oral surgeon, or orthodontist (brace)?

Please list: ____

Please check all that apply:

- ☐ I currently or previously have had habits of clenching or grinding
- ☐ I currently use a night guard while sleeping
- ☐ I have had problems with dental anesthetic in the past

  If yes, please explain ____
- ☐ I have had previous orthodontic treatment (Date completed: __________________)
- ☐ I have had previous dental trauma (Date: ______________________)

I, the undersigned, affirm the information above is accurate and complete to the best of my knowledge. I will not hold Dr. Barr, Dr. Spencer, Dr. Yavorek or any member of the office staff responsible for problems arising from errors or omissions that I made in the completion of this form. I consent to any advisable and necessary endodontic therapy to be administered by Dr. Barr, Dr. Spencer, Dr. Yavorek and staff for diagnostic purposes or dental treatment.

____

Patient's (or Parent/Legal Guardian) Signature **Date**

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Office Payment Policy

Payment in full is expected at the time service is rendered. Endodontic treatment may take one or more visits, depending on the difficulty. If another appointment is needed, there may be an additional fee.

Fees for endodontic treatment and surgical procedures range from $1,550 to $2,100. If your appointment is for an evaluation, the fee ranges from $250 to $475. If your tooth requires a medication treatment (calcium hydroxide), there will be an additional $200 fee (in addition to the root canal treatment fee). The need for this will be determined before or during the course of treatment. Certain circumstances may necessitate a fee for follow up care.

Accepted Methods of Payments:

☐ **Cash** ☐ **Credit Card** (We take all major credit cards, including VISA, MC, DISC and AE)

☐ **Debit Card** ☐ **Care Credit®**

☐ **Personal Check** (Checks are processed electronically and will be provided to you as a receipt of the transaction)

I, the undersigned, have read the above information. I certify that I am the patient or the custodian/agent of the patient authorized to furnish the information requested. I understand and agree that even if I have dental insurance, I am responsible for payment of services at time of treatment.

____

Patient's (or Parent/Legal Guardian's) Signature **Date**

Insurance:

If you have ***dental insurance***, we will help you file your claim to make the reimbursement process as easy and convenient for you as possible. ***We do not accept insurance as a form of payment for your endodontic treatment.*** Reimbursements of insurance benefits will be made directly to you. This office does not accept worker's compensation.

Please provide the office with a copy of your insurance card and fill in the required information below.

Insurance Carrier and Address:____

Subscriber's Name, Date of Birth, and Relationship:________________________________

Group Number: ________________________ID Number:______________________

Consent for Endodontic Treatment

Root canal treatment is an attempt to save a tooth which otherwise may require extraction. It should be a very positive experience. While you may be anxious, the doctors and staff will explain the need for treatment, the process involved and provide post-operative instructions concerning your comfort and final restoration of the treated tooth. Success of treatment is dependent upon many variables that are not under the control of the dentist or patient. Based on scientific literature, root canal therapy is successful 85-98% of the time. It is important that you understand and accept the potential complications that may occur during treatment and may affect the outcome of treatment. Such complications include, but are not limited to the following:

Post-operative discomfort lasting a few hours to a few days that may require pain-relieving medications as deemed necessary by the dentist.

Post-operative swelling of the surrounding gum tissue or face that may require antibiotics as deemed necessary by the dentist.

Separation of instruments in the canal that may, at the judgment of the dentist, be left in the canal or require surgery for healing.

Perforation of the tooth/root that may require additional treatment and associated fees or result in loss of the tooth.

Crack or fracture of the tooth/restoration (especially porcelain restorations) during treatment that may require a new restoration and/or possibly loss of the tooth. Permanent crowns may come off during treatment and require replacement.

Inability to complete root canal treatment due to calcifications, which may require additional treatment and associated fees or result in loss of the tooth.

Complications associated with the administration of local anesthetics, including allergic reaction, fainting, heart palpitations, overdose, bruising, numbness and hematoma, which may last for days/ weeks/ months/ permanently.

Exacerbation/creation of TMJ/TMD symptoms due to the length of time required to maintain an open mouth during root canal therapy procedures.

Complications associated with past or current use of bisphosphonate therapies (i.e. Actonel®, Boniva®, Fosamax®, or Zometa®), which may impact surgical or non-surgical endodontic treatment.

Following the completion of root canal therapy, it is crucial that you return to your dentist for definitive restoration of the treated tooth. This should be done within 2-4 weeks, unless you continue to have symptoms. If this occurs, please contact our office for further evaluation. Failure to complete this important phase of treatment may result in recontamination of the root canal system. This may lead to the need for retreatment, surgery or result in loss of the treated tooth.

I am aware that root canal treatment is the best attempt to save a tooth that would otherwise require extraction.

I agree that this constitutes full disclosure and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs, and that I have had sufficient opportunity for discussion and to ask questions.

The goal of this office is to provide the best endodontic care in a secure and compassionate environment. Your comfort is our main consideration. We trust that your experience in our office will be satisfying. Please sign and date this form indicating that you have read and understand the information. If you have any questions regarding treatment, please ask Dr. Barr, Dr. Spencer, or Dr. Yavorek.

Patient's (or Parent/Legal Guardian's) Signature **Date**

Doctor's Signature **Date**

Authorization for Release of Information – Compound Release

Name of Patient ____ Date of Birth ______________

_Endodontic_Specialists_______________________________ is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays Other_____________________________
☐ Spouse (provide name and phone number) ____________________________________	☐ Financial ☐ Medical
☐ Parent (provide name and phone number) ________________________________	☐ Financial ☐ Medical
☐ Email communication-Provide email address* __________________________________ *In order for email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Breach notification
☐ For email communication I understand that if email is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email communication,	
☐ Communication about treatment alternatives even if this office is being compensated for making the communication.	

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

____Date ___________________

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

____

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Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I,______________________________________, have received a copy of the Privacy Practices for this office.
Printed Name

____
Patient's Signature (Parent/Guardian) Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however the acknowledgement could not be obtained due to the following:

- [ ] Individual refused to sign
- [ ] Barriers in communication prohibited obtaining the acknowledgement
- [ ] An emergency situation prevents us from obtaining the acknowledgement
- [ ] Other Please Specify____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED BY ENDODONTIC SPECIALISTFS AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY**.**

YOUR RIGHTS: When it comes to your health information you have certain rights. This section explains your rights**.**

Upon written request:

- Ask to see or get an electronic or a paper copy of your health record or other information we have about you. We will also provide a summary of your health information if requested. We will charge a reasonable, cost based fee. We will provide this information as soon as possible but no later than 30 working days of the request.
- Ask us to correct your health information you think is incorrect or incomplete. We may say “no” but will tell you why in writing within 60 days.
- You can ask us to communicate with you in a certain way (for example, home or office phone) or to send mail to a different address. We will accommodate all reasonable requests.
- Ask us not to use or share certain health information for treatment, payment or our operations. We are not required to agree with your request and may say “no” if it would affect your care.
- If you pay for a service or health care item out of pocket in full and you ask us not to share that information for payment or our operations with your health insurer we will agree unless we are required by law to share that information.
- Ask us for a list or an accounting of the times we have shared your health information for reasons other than treatment, payment, healthcare operations, and when you have asked us to share information. We will provide a list for the past six years for the request. One request per year will be provided free of charge. For additional requests we will charge a reasonable, cost based fee.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

You may also:

- Choose someone to act on your behalf. If you have given someone medical power of attorney or they are your legal guardian, that person can exercise your rights and make choices about your health information. We will ask for proof of this relationship before we take any action.
- Ask for a paper copy of this document even if you have agreed to receive the notice electronically. We will provide that copy promptly.
- File a complaint if you feel your rights have been violated you may contact the designated Privacy Officer, Leisa Brito, 15 Yorkshire Street, Suite 102, Asheville, NC, 28803 (828) 277-7668, lbrito@wncendo.com
- File a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate for filing a complaint.

OUR RESPONSIBILITIES: The law requires us to:

- Maintain the privacy and security of your protected health information.
- Notify you promptly if a breach occurs that may compromise the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy of it.
- Not to use or share you information other what is described in this notice unless you tell us we can in writing. If you tell us we can and then change your mind, just let us know in writing you have changed your mind.

(over)

YOUR CHOICES - For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in situations described below, talk to us.

- In these cases you have both the right and the choice to tell us to: share information with your family, close friends, or others involved in your care and share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases we never share your information unless you give us written permission:
  - Marketing purposes
  - Sale of your information
  - In the case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURE – We typically use or share your health information in the following ways:

Treatment: We can use your health information and share it with other professionals who are treating you. Example: we may share your health information to an outside doctor for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment.

Payment: We can use or share your health information to bill and get payment from health plans or other entities. Example: we give information about you to your health insurance plan so it will pay for your healthcare.

Health Care Operations: We can use and share your health information to run our practice, improve you care, and contact you when necessary. Example: we use health information about you to manage your treatment and services.

Other ways we can use or share your health information – We are allowed or required to share you information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

- **Help with public health and safety issues:** We can share health information about you for certain situations such as: preventing disease, helping with product recalls, reporting adverse reactions to medication, reporting suspected abuse, neglect, or domestic violence, and preventing or reducing a serious threat to anyone's health and safety.
- **Comply with the law**: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see if we are complying with federal privacy law.
- **Respond to organ and tissue donation requests:** We will share health information about you with organ procurement organizations.
- **Work with a medical examiner or funeral director:** We can share health information with a coroner, medical examiner, or funeral director when you die.
- **Address workers' compensation, law enforcement, and other government requests:**
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services
- **Respond to lawsuits and legal actions:** We can share your health information to respond to a court or administrative order, or in response to a subpoena.
- **Research:** We can use or share your information for health research.

CHANGES TO THIS NOTICE - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office and on our website.

Leisa Brito, Practice Manager
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(828) 277-7668

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