Accardo
Endodontics

FOR OFFICE USE ONLY

BP: _____

TEMP: _____ **HR:** _____

REFERRAL: _____ **HW:** _____ **MR:** _____

PATIENT INFORMATION ☐ Male ☐ Female Preferred Title/Prefix/Pronoun: _____ Driver's License #: _____

Name: _____ ☐ Minor Date of Birth: _____

Address/City/State/ZIP: _____ Phone #: _____

Email: _____ Alternate Phone #: _____

Emergency Contact Name: _____ Phone #: _____

RESPONSIBLE PARTY ☐ Same as above Relationship to the patient: _____

Name: _____ Date of Birth: _____

Address/City/State/ZIP: _____ Phone #: _____

MEDICAL HISTORY Physician: _____ Office Phone #: _____ Last Exam Date: _____

Are you currently under the care of your physician or other medical provider for any medical conditions? ☐ No ☐ Yes (please describe below):

OR

Have you ever been hospitalized for any surgical operation/serious illness? ☐ No ☐ Yes (please describe below):

_____

_____

_____

_____

Are you taking or have you EVER taken bone density medications (bisphosphonates) such a Fosamax, Boniva, Actonel, Binoto, Zometa, Reclast, Aclasta, Skelid, Didronel, Prolia or Aredia? ☐ No ☐ Yes

LIST ALL MEDICATIONS or supplements you are currently taking or have taken within the past 3 months, including non-prescription medications:

_____

_____

_____

_____

Please indicate which of the following medical conditions applies to you; check only if the answer is YES.

☐ High Blood Pressure	☐ Emphysema	☐ Gastrointestinal Condition	☐ Organ Transplant	☐ Psychiatric Care
☐ Heart Condition	☐ Lung Condition	☐ Ulcers	☐ Joint Replacement	☐ Anxiety
☐ Heart Attack or Stroke	☐ Tuberculosis	☐ Headaches	☐ Arthritis	☐ Depression
☐ Chest Pain/Angina	☐ Asthma	☐ Epilepsy/Fainting	☐ Anemia	☐ Past Smoker
☐ Heart Murmur/Defect	☐ Thyroid Condition	☐ Neurological Condition	☐ Bleeding Disorder	☐ Current Smoker
☐ Irregular Heart Beat	☐ Hormonal Condition	☐ Tumor/Neoplasm	☐ Blood Condition	☐ Addiction or Drug Use
☐ Rheumatic Fever	☐ Diabetes	☐ Cancer	☐ Infectious Illness	☐ Alcoholism
☐ Pacemaker	☐ Pancreatic Condition	☐ Radiation	☐ STD	☐ Glaucoma or Visual
☐ Heart/Vascular Stent	☐ Gallbladder Condition	☐ Chemotherapy	☐ HIV/AIDS	☐ Other: _____
☐ Artificial Heart Valves	☐ Kidney Condition	☐ Immunotherapy	☐ TMJ Disorder	_____
☐ Heart Surgery	☐ Liver Condition	☐ Fatigue	☐ Swelling	_____
☐ Shortness of Breath	☐ Hepatitis	☐ Autoimmune Disease	☐ Skin Condition	_____

WOMEN: Are you pregnant or think you may be pregnant? ☐ No ☐ Yes **Gestational Week:** _____ **Breast Feeding?** ☐ No ☐ Yes

ALLERGIES: ☐ Latex ☐ Penicillin ☐ Sulfa Drugs ☐ Other Antibiotics ☐ Codeine/Opioids ☐ Iodine ☐ Local Anesthetics ☐ Aspirin/NSAIDS

FOOD or OTHER ALLERGIES: _____

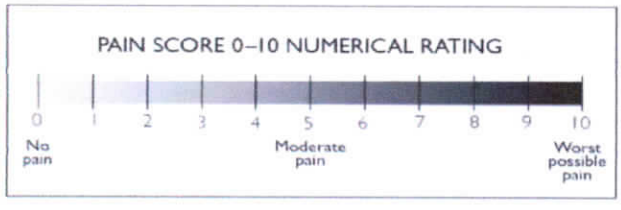
DENTAL HISTORY General Dentist: _____ Last Exam Date: _____

Reason for Today's Visit: _____

_____

_____

Tooth # or Area of Concern: _____



GENERAL CONSENT

I certify that I have read and understand the above information and to the best of my knowledge, have answered accurately. I understand that providing incorrect information can be dangerous to my health. By providing contact information, I consent to be contacted regarding but not limited to diagnosis, treatment, appointments, follow-up care, marketing and financial obligations via text messages, email, or phone calls from Accardo Endodontics, LLC. I am aware there is some level of risk that third parties might be able to read unencrypted text messages or emails.

I consent to an endodontic exam, which may consist of a physical exam, radiographs (x-rays) or CT scans, and includes the possible administration of dental (local) anesthetic. Risks of local anesthesia include but are not limited to: dizziness, nausea, vomiting, altered heart rate or allergic reaction which may require medical management or hospitalization, restricted mouth opening, muscle soreness, prolonged numbness which may result in biting injury, injury to nerves resulting in pain, numbness, tingling or sensory disturbances which may be transient or permanent as well as possible breakage of the needle into soft issues. You have the right to reject or accept any proposed treatments.

Patient or Parent/Guardian Signature: _____ Date: _____

FINANCIAL POLICY

The full fee or an estimated portion of your fee will be due the day of service or the first day of treatment if multiple visits are needed. We accept most credit cards, Care Credit Financing, cash, cashier's checks, money orders and personal checks. Checks that are not honored will incur a returned check fee of $25.00 and additional fees could result. You will have 10 days to reimburse payment in the form of cash, cashier's check, or money order.

Patient or Parent/Guardian Signature: _____ Date: _____

HIPPA: ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

This notice can be obtained at the office and describes how we protect your private information. You may refuse to sign this acknowledgement.

Patient or Parent/Guardian Signature: _____ Date: _____

PHOTO RELEASE CONSENT FORM

I understand that photos, radiographs or CT scans taken are part of my health records and may be used for communication with other health care professionals related to my care, third party payees (your insurance company) or as required by law.

***IN ADDITION**, I authorize Accardo Endodontic, LLC to take photographs and videos of my teeth, jaws, and face and that the print, visual and/or electronic media can be used for communication with other health care professionals not related to my care, educational publications, marketing online or in print, and/or lectures. I understand that I will not be identified by name in any published or educational materials and my identity will not be revealed in the photographs. I do not expect compensation, financial or otherwise for the use of these images.*

Patient or Parent/Guardian Signature: _____ Date: _____

DENTAL INSURANCE POLICY

Accardo Endodontics, LLC will file your dental insurance claim on your behalf; however, there is a processing fee of up to $25 per claim. We will determine your estimated fee based on your primary insurance plan only. As a courtesy, we will provide a reasonable amount of assistance in filing secondary claims in certain circumstances. We reserve the right to charge our full fee regardless of any insurance coverage you may have. Depending on your insurance, you may also owe a deductible. We do not participate as an in-network provider for any insurance carriers and we do not accept discount plans. If your insurance company has not paid the claim within 90 DAYS from the start of treatment, you will be held responsible for the payment in full unless other arrangements have been made. If you are owed money back after the insurance claim has been processed, we will mail a refund check to you within 90 DAYS after the insurance claim payment is received. If we are filing a dental insurance claim on your behalf and you elect to pay an estimated portion of the fee, we will ask for a credit/debit card to retain on file. Your credit/debit card information will be encrypted securely. Once your insurance claim as been processed or 90 DAYS after completion of your treatment, your balance will be automatically charged to the credit/debit card on file. If you do not wish to leave a credit/debit card on file, we will ask for full payment at the time of service.

I authorize Accardo Endodontics, LLC to release any pertinent information, including the diagnosis and records of any treatment or examinations rendered to third party payers for submission of a dental insurance claim. I understand that I will need to keep a credit card number on file for any outstanding balances to my account. I authorize and request my insurance carrier to pay directly to Accardo Endodontics, LLC. I understand that my insurance carrier may pay less than the actual fee for services and I agree to be responsible for the payment of all services rendered on my behalf. I authorize Accardo Endodontics, LLC to charge my credit/debit card for any remaining balances after my insurance carrier has paid its portion or if my insurance carrier has not paid within 90 days.

Patient or Parent/Guardian Signature: _____ Date: _____

DENTAL INSURANCE INFORMATION (please complete below OR provide a copy of your dental insurance card)

Subscriber's Name (if different from patient's name): _____

Relationship to the patient: _____ Subscriber's Date of Birth: _____

Subscriber's Address/City/State/ZIP: _____

Insurance Company: _____ Insurance Company Phone #: _____

Member ID#: _____ Group #: _____ Subscriber's SSN# (optional): _____