Leominster Endodontics
Root Canal Specialist

Registration

Last Name	First		M.I.
Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	
Birth Date / Age	O Male O Female	Referred By	
Social Security No. - -	E-Mail Address		

Dental Insurance

Primary Insurance		Secondary Insurance	
Insurance Company		Insurance Company	
Group No.		Group No.	
Employer Name		Employer Name	
Subscriber Name	DOB	Subscriber Name	DOB
Insured's I.D. #		Insured's I.D. #	
Insured's Soc. Sec. #		Insured's Soc. Sec.	
Relationship to Patient		Relationship to Patient	

Parent Guardian Information

Person Responsible for Patient:		
Relationship to Patient	Soc Sec # - -	
Address:		
City:	State:	Zip:
Phone#:	Work#:	

Consent for Treatment

A. I authorize the doctor or his/her staff to take x-rays, photographs, make models, or conduct other tests deemed necessary in order to make a thorough diagnosis by the doctor.
B. After making such diagnosis, I give permission to undertake the recommended treatment plan that has been mutually agreed upon.
C. I agree to the use of anesthetics and other medication as necessary, and further understand that these may carry certain risks. I understand that I may ask the doctor for a complete listing of possible complications.

Patient's Signature (if over 18) (X)_____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness: _____

Financial Policy Agreement and Cancellation Policy

If you have insurance, it is your responsibility to understand your insurance and what dental procedures your insurance will and will not pay. At Leominster Endodontics we will work to help you better understand your insurance, but any estimates made by this office to calculate your insurance benefit is only that of an estimate. We will make good faith estimates and defer billing you for that amount up to 60 days. We will file the appropriate forms with your insurance company that you provide us with your personal information including social security number and date of birth. If your insurance denies coverage, or if we do not receive payment within 60 days from the date of services rendered, that amount will then become due and payable by you, regardless of any estimates given to you by this office. Please remember that your coverage is a contract between you and your insurer and /or your employer. Although we will make every effort to help you obtain and understand your benefits, we cannot guarantee what your insurance will pay.

Your payment is due at time of service

Fees for treatment are due at the time treatment is rendered after the deduction of your insurance benefit estimate as described above.
Payment options: Cash, Check, Debit Card, Credit Card (Visa, Master card, Discover Card, American Express)

Patient Responsibility

I acknowledge my responsibility for payment of services rendered by Leominster Endodontics in accordance with Leominster Endodontics fees and terms. I understand my responsibility is not modified by whether any third party (insurance) pays for all, part or none of the charges. If the balance on your account is not paid within 60 days of statement, your account will become delinquent and will be forwarded to a third-party collection agency. If this becomes necessary additional fees may be added to cover handling charges. If your account falls delinquent after 60 days an interest rate of 5.0% will be charged to your account every 90 days.

Assignment and release

I authorize payment to be made directly to the dentist by my insurance company and I accept financial responsibility for all service not covered by my insurance and I authorize release of any medical care information requested by my insurance carrier. This agreement becomes effective the date the patient begins their first visit with Leominster Endodontics.

Cancellation Policy

All appointments when made have a specific date, time of day, and length of stay so that you are more efficient with your time here. With this in mind, we have developed a cancellation policy that is fair to both our patients and our practice. Late cancellations (less than 48 business hours' notice) failed appointments and late arrivals are disruptive to our schedule and other patients. In order to maintain our schedule, we request 48 business hours' notice for cancelations or rescheduling of appointments. In the instance of a late cancellation (less than 48 business hours' notice) or a failed appointment there may be a $30.00 charge per hour of scheduled appointment.

Signature: (X)_____Date: _____

Leominster Endodontics

Medical History-

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you taking any blood thinners or anticoagulants?	◯ Yes ◯ No	If yes
Do you premedicate for dental visits (take antibiotics 1 hr before per a doctor)?	◯ Yes ◯ No	If yes
Have you had any joint replacements? If yes:which joint and when	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes

Allergies

Any allergies to antibiotics?	◯ Yes ◯ No	If yes
Any allergies to pain medication?	◯ Yes ◯ No	If yes
Latex allergy?	◯ Yes ◯ No	If yes
Other allergies?	◯ Yes ◯ No	If yes

Women

Are you...

Pregnant/trying to get pregnant?	◯ Yes ◯ No	Nursing?	◯ Yes ◯ No	Taking oral contraceptives?	◯ Yes ◯ No

Do you have, or have you had, any of the following?

Artificial Heart Valve	◯ Yes ◯ No	Raditation Therapy	◯ Yes ◯ No	Asthma	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	COPD/Emphysema	◯ Yes ◯ No
History of Infective Endocarditis	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Pacemaker	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No
Irregular Heart Beat	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Rhematoid Arthritis	◯ Yes ◯ No
Heart attack	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Stroke	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Sinus trouble	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Blood Disorder	◯ Yes ◯ No	Alzheimers	◯ Yes ◯ No
Heart Disease	◯ Yes ◯ No	Epilepsy	◯ Yes ◯ No	Aids/HIV	◯ Yes ◯ No
Kidney Problems	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Psychiatric care	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No
Liver Disease	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No		

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

Patient Signature (or guardian):

X_____ Date:_____

Doctor Signature:

X_____ Date:_____

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Acknowledgement of Receipt of Statement of Privacy Practices/Cancellation Policy and Financial Policy

I acknowledge that I have received a copy of the Statement of Privacy Practices and the cancellation policy for the office of Leominster Endodontics. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility. We reserve the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. We reserve the right to change our privacy practices at any time. You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Leominster Endodontics. We may decline treatment if you revoke this consent.

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

1. Permission to Use and Disclose My Health Information. By signing this form, I give Leominster Endodontics permission to use and/or disclose my health information to carry out treatment, payment or health care operations.
2. Right to Refuse. I have the right not to sign this consent. If I refuse to sign this consent Leominster Endodontics will not provide me with treatment until I consent. However, treatment required by law, such as emergency care, can be provided to me whether or not I sign this consent.
3. Right to Review Notice of Privacy Practices. Leominster Endodontics has provided me with a copy of their Notice of Privacy Practices which describes how they may use and disclose my health information. I have the right to review this notice before signing this consent.
4. Changes to the Privacy Notice. We may change the Notice of Privacy Practices as needed. I may obtain a current copy of Notice of Privacy Practices by contacting Leominster Endodontics.
5. Right to Request Restrictions on Use/Disclosure. I have the right to request to restrict how Leominster Endodontics uses and/or discloses my protected health information for the purpose of providing treatment, obtaining payment for services, and/or conducting health care operations. We are ***not required*** to agree to any restriction I request. If we decide to agree to the request, it must restrict their use and/or disclosure of my health information the way I asked. Because of the number, complexity, and nature of the services we deliver, we will rarely agree to requests to restrict uses and disclosures of my health information for the purposes of treatment, payment, and healthcare operations. If I wish to request restrictions, I can contact Leominster Endodontics and they will notify me of the decision to accept or decline my restrictions.
6. Right to Withdraw Consent. I have the right to withdraw this consent at any time. I must do this in writing. If I want to withdraw this consent, I can contact 80 Erdman Way Leominster, MA 01453. Note that my withdrawal of this consent will ***not*** be effective for uses and/or disclosures that have already been made based on my prior consent. If I withdraw this consent, then by law, Leominster Endodontics is unable to provide me with further treatment or follow-up, other than required emergency services.
7. Effective Period. This consent is active unless and until I withdraw it in writing.
8. References to “I” or “me”. References to “I” or “me” in this Consent include the individual for whom the signing party is authorized to sign. If I am signing this consent on behalf of another person, it is because I am the legal guardian, parent, or agent under an active Power of Attorney for Health Care and am legally authorized to sign this Consent on behalf of the individual.

Signature of Patient :(**X**) _____ Date ___/___/_____
Or Guardian

Witness Signature: _____ Date ___/___/_____