PATIENT REGISTRATION

Name: _____ Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ Zip: _____

Social Security Number: _____ Birthdate: _____

Check One ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient or Parent's Employer: _____ Work Phone: _____

Spouse or Parent's Name: _____ Work Phone: _____

RESPONSIBLE PARTY (If under the age of 18)

Name: _____ Relationship to Patient: _____

Address: _____ Home Phone: _____

Driver's License #: _____ Birthdate: _____

Employer: _____ Work Phone: _____

OFFICE PAYMENT POLICY

The best doctor-patient relationships are maintained when there is complete understanding of the treatment rendered and the fee. Please initial here that you have read and understand this policy_____.

As a courtesy we will submit dental insurance, but we cannot accept the responsibility for collecting insurance payments or for negotiating a dispute claim. Insurance is a contract between the patient and the insurance carrier. Even though you may be covered by dental insurance, there will be a co-pay due on the day of your visit. You can expect either an overpayment refund or a bill for the uncovered portion of the insurance payment after our office has received it, since it is not possible to predict the exact amount of the insurance payment prior to the initiation of treatment. Please initial here that you have read and understand this policy_____.

For your convenience we offer the following methods of payment: Please check your intended method of payment:

☐ Visa-Master Card; Discover Card ☐ Personal Check ☐ Cash

DENTAL INSURANCE (Please inform the front desk if you have secondary dental insurance)

Subscriber: _____ Relationship to patient: _____

Date of Birth: _____ Social Security Number: _____

Name of Employer: _____ Work Phone: _____

Insurance Company: _____ Group Number: _____

Insurance Company Address: _____ Phone Number: _____

I authorize release of any information relating to this insurance claim. I understand that my dental insurance may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents. I authorize and request my dental insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

Signature of Patient, Parent or Guardian: _____

We do take our patient's health information privacy seriously, and we will make every effort to protect that information. It is our policy that we only disclose patient health information about treatment, payment, and healthcare operations. Any other disclosure of healthcare information would require a written authorization except for communication to the referring general dentist or other medical/dental specialist directly involved in your treatment.

Signature of Patient, Parent or Guardian: _____

You may refuse to sign this acknowledgement

Patient Name: _____ Date: _____

List name of person we are able to discuss your treatment with:

_____

I have read and received a copy of the Notice of Privacy Practices for Dr. Gregory C Gell DDS MS

Patient Signature: _____ Date: _____

For office Use Only

We are unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practice because:

- **An emergency existed and a signature was not possible at the time**
- **The individual refused to sign**
- **A copy was mailed with a request for a signature by mail**
- **Unable to communicated with patient for the following reasons:**

Other: _____

Prepared by: _____

Signature: _____ Date: _____

Referred to office by: _____

CONFIDENTIAL HEALTH HISTORY

Medical Doctor Name: _____

Phone Number: _____ Fax Number: _____

Do you have or have you ever had a history of the following medical conditions? (Please Check):

- **____ High or Low Blood Pressure**
- **____ Heart murmur or prolapsed valve**
- **____ Joint prosthesis (hip, knee, etc.)**
- **____ Rheumatic Fever or rheumatic heart disease**
- **____ Congenital Heart Disease**
- **____ Cardiovascular disease: heart attack, stroke or bypass**
- **____ Prosthetic heart valve**
- **____ Blood Disorder (e.g. anemia)**
- **____ Venereal disease**
- **____ Asthma**
- **____ ALLERGY TO LATEX**
- **____ Low blood pressure**
- **____ Chest pain, angina**
- **____ Swollen ankles, arthritis or joint disease**
- **____ Cardiac pacemaker**
- **____ Heart Surgery**
- **____ Delay in healing**
- **____ Tuberculosis**
- **____ Emphysema**
- **____ X-Ray treatment or chemotherapy**
- **____ On a diet**
- **____ History of alcohol abuse**
- **____ Eye disease or glaucoma**
- **____ Infectious mononucleosis**
- **____ Sinus Trouble**
- **____ Thyroid problems**
- **____ Diabetes**
- **____ Stomach ulcers, colitis**
- **____ Hepatitis, jaundice, liver disease**
- **____ Kidney problems**
- **____ Psychiatric treatment**
- **____ Fainting spells or seizures**
- **____ Epilepsy**
- **____ Cancer**
- **____ Temporomandibular joint problems (TMJ)**
- **____ Low blood sugar**
- **____ Dialysis**
- **____ Irregular heart beat**
- **____ Contagious diseases**
- **____ Bronchitis, chronic cough**
- **____ Hay fever or sinus problems**
- **____ Problems with the immune system**
- **____ Difficult breathing or other lung trouble**
- **____ Chronic fatigue or night sweats**
- **____ Wear contact lenses**
- **____ Bruise easily**
- **____ Gallbladder trouble**

If yes to any above please describe: _____
Have you travelled to: Liberia, Sierra Leone or Guinea in the last 21 days? _____
If yes, please let us know when you arrived into the U.S.? _____ Are you feeling feverish? _____
Do you require antibiotic premedication for endocarditis (SBE Prophylaxis)? _____
Do you require oral sedation prior to dental treatment? (If yes, why)? _____

List all medications currently taking:

Medication:	Action:
_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic or do you suffer ill effects from the following;
_____ Penicillin(s) _____ Aspirin _____ Codeine Others: _____

<u>Women Only</u>: Are you pregnant? _____ If Yes What Month? _____
Are you currently taking birth control/hormonal medication? _____
Please note that antibiotic medication may reduce the effectiveness of hormonal birth control.
Please initial to acknowledge this warning _____

I affirm that the above information is accurate and complete to the best of my knowledge:

Signature: _____ Date: _____
(Patient or Legal Guardian)

Update: _____ Date: _____

CONSENT TO EXAMINE AND TREAT

You have been referred for endodontic (root canal) evaluation and possible treatment. The initial consultation consists of history taking, clinical examination, appropriate tests, and diagnostic radiographs. A diagnosis and treatment recommendation will be presented.

Root canal therapy is completed in one or more separate appointments based on the unique diagnosis and complexity of the treatment. The objective of endodontic treatment is to prevent or eliminate infection within the root canal system so the tooth can be maintained in a normal healthy manner with relief from pain. This will require the removal of pulp tissue from the root canal system, which may require disinfection with intracanal medication. Radiograph will be required for endodontic treatment. Local anesthetics will usually be required. Antibiotics and analgesics may also be required. Typically only mild discomfort is expected for a few days following treatment which will be controlled well with over the counter analgesia. Severe pain may occur following endodontic treatment, but this is unusual, and is typically associated with preoperative pain from endodontic abscesses.

The following possible risks may occur at any time during treatment:

RISKS: Complications resulting from, but not limited to the use of dental instruments, drugs, anxiety sedation, medicines, anesthetics and injections. These complications include, but are not limited to swelling, sensitivity, bleeding, pain, and infection. Numbness and tingling sensation in the lip tongue, chin, gum, cheeks, and teeth which may be transient, or on rare occasions permanent reactions to injections, root canals surgery, changes in occlusions, temporal mandibular joint disorder (TMD/TMJ). Referred pain to the ear, neck and head may occur. Nausea, vomiting, allergic reaction are possible.

RISKS MORE SPECIFIC TO ENDODONTIC TREATMENT: Possibility of broken endodontic instruments within the root canals, perforations (extra openings in the crown or root of the tooth), damage to existing restorations such as crowns, bridges, porcelain veneers, and fillings. Loss of sound tooth structure in gaining access to the root canals is usually necessary. Fracture of the remaining crown (cracked tooth) prior to permanent restoration by the general dentist, which may result in loss of the tooth following endodontic dental surgery, such as; blocked canals due to fillings, prior treatment, natural calcification (extremely small canals), broken instruments, curved roots, periodontal (gum) disease, splits or fractures of teeth.

TREATMENT CHOICES OTHER THAN ENDODONTIC THERAPY: Tooth extractions or the choice of no treatment are the two alternative treatments. Risks involved in these choices will generally be greater than pursuing endodontic treatment, and may include; pain, local infection, spreading infection, swelling, and loss of teeth.

ACKNOWLEDGEMENT AND CONSENT: I, the undersigned, being the patient or guardian of minor patient, acknowledge that I have read this form and consent to the performance of the described and recommended endodontic and dental procedures. I reserve the right to refuse further treatment at any time and accept the consequences of that decision. I also understand that I may need to return to my general dentist in a timely manner following endodontic treatment or permanent restoration of the tooth, and failure to do so may result in the failure of the endodontic treatment provided secondary to bacterial contamination with breakdown and leakage of a temporary filling.

I understand that endodontic treatment is an attempt to save a tooth, which may otherwise require extraction. Although endodontic treatment (root canal therapy) has a high degree of success, it cannot be guaranteed and additional treatment such as endodontic retreatment, endodontic surgery or extraction may be required.

Date: _____ Signature: _____

Date: _____ Witness: _____