Citrus Endodontics, P.A. • 9401 SW Highway 200, Suite 402 Ocala, FL 34481 • (352) 873-4222

Patient Information

Name: Home Phone:

Parent's Name (if minor): Wk. Phone: Cell Phone:

Address: City State Zip

Social Security # Date of birth:

Spouse's Name: Wk. Phone:

Nearest relative not living with you: Phone:

Physician: Phone:

Dentist: Pharmacy: Phone:

Who may we contact in the case of an emergency? Phone:

Who may we thank for referring you to us? Phone:

Dental Insurance Carrier: Group #:

Insurance Address: Ins. Phone:

Policy Holder's Name: DOB: SS#

I will be paying today by: □ cash □check □ credit card □ Care Credit

Payment is due at time of service. We will file dental insurance for you, but cannot accept dental insurance as payment.* Your dental insurance company will reimburse you as stated by your plan. Care Credit financing is available to those who qualify.

**We are providers for Delta, Aetna, United Concordia, and CIGNA and will accept the predetermined coverages under each plan as payment.*

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all of the information on this sheet and certify that the information given is true and correct to the best of my knowledge. I will notify Citrus Endodontics, P.A. of any changes in my status or the above information.

Signature *Date*

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Medical History

• High Blood Pressure • Respiratory/Asthma • Rheumatic Fever • Hypertension/Circulation • Immunocompromised • Anemia/Bleeding • Diabetes/Kidney • Herpes • Thyroid/Hormonal • Hypoglycemia • Shortness of breath • Cancer • Radiation/Chemotherapy • Tuberculosis • Fatigue • Swelling • Ulcers/Digestive • Migraines/Headaches • Epilepsy/Fainting • Glaucoma/Visual • Mental/Neural	• Tumor/Neoplasm • Infections Disease • Venereal Disease • TMJ • Heart Disease • Heart Murmur/Defect • Pacemaker • Heart Attack • Stroke • Irregular Heartbeat • Prosthetic Implant • Any Transplant • Joint Replacement • Arthritis • Nose Obstruction • Recent Illness **Others:** _____ _____ _____ _____	**Allergies:** Penicillin Antibiotics Aspirin Tylenol Codeine Narcotics Local Anesthetic Latex Valium/Tranquilizer Nitrous Food **Others/Specify:** _____ _____ _____ _____ _____ _____ _____ _____

Current Medications:_____

_____

_____

Have you ever taken bisphosphonates (used for osteoporosis)?	Yes	No
Must you sleep with your head on more than one pillow?	Yes	No
Have you ever been put to sleep for an operation?	Yes	No
Are you pregnant?	Yes	No
Are you under the care of a physician?	Yes	No
Have you ever responded unfavorably to medical or dental care?	Yes	No
Do you get short of breath after a little exertion?	Yes	No
Have you been hospitalized within the last 5 years?	Yes	No
Have you traveled out of the U.S. within the last three weeks?	Yes	No

If so, where have you traveled? _____

Other Remarks:_____

Name:_____

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HIPAA REGULATIONS

I hereby give consent to Citrus Endodontics, P.A. to use and disclose my protected health information for the purposes of treatment, payment, and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered in person or by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that we or others have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information fore the purposes of treatment, payment, or health care operations. We are not required to grant your request; however, if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review or Posted Privacy Policy before you sign this contract.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy by calling (352) 873-4222.

Printed Name of Patient_____
Signature_____

If you are signing as the patient's representative:
Print your name_____
Relationship_____

Cancellation

I hereby void the consent given above.

Printed Name of Patient_____
Signature_____ ***Date***_____

If you are signing as the patient's representative:
Print your name_____
Relationship_____

Your cancellation will be effective, upon receipt, at the following address:
Citrus Endodontics, P.A.
9401 SW Highway 200, Suite 402
Ocala, FL 34481

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INFORMED CONSENT

The following is important information you need in order to make your decision about treatment. Please carefully read each statement and **initial** on the lines provided.

____ Root canal therapy is a procedure designed to retain a tooth which may otherwise require extraction. Root canal therapy has a very high degree of success. However, it is a biological procedure and results cannot be guaranteed.

____ Occasionally, a tooth that has undergone non-surgical root canal therapy may require re-treatment or root canal surgery.

____ We make special efforts to preserve the crowns of teeth, but despite our best efforts, a porcelain crown may fracture and require a new restoration.

____ Even after root canal therapy, approximately 5% of endodontically treated teeth may eventually require extraction.

____ Final restoration (crown) of a tooth that has undergone root canal therapy is essential for retention of the tooth. **A final restoration should be completed within 30 days of root canal therapy. Final restorations are provided by your restorative dentist.**

_____ _____

Signature of Patient (or Parent) Date

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CONTACT PERMISSIONS

Do we have permission to contact you at home regarding your treatment and appointments? Y/N

Do we have permission to contact you at work regarding your treatment and appointments? Y/N

Do we have permission to speak with anyone in your household regarding treatment? Y/N

Names and relationship, if applicable:

Name	Relationship
_____	_____
_____	_____
_____	_____

Do we have permission to speak with anyone in your household regarding appointments? Y/N

Names and relationship, if applicable:

Name	Relationship
_____	_____
_____	_____
_____	_____

_____ _____

Signature of Patient (or Parent) Date