PATIENT INFORMATION

PLEASE PRINT ALL INFORMATION.

Date _____

Name _____

Nickname (name you go by) _____

Address _____

City, State, Zip Code _____

Home Ph. _____ Cell Ph. _____ Marital Status _____

Date of Birth _____ Social Security Number _____

Dentist (who referred you today?) _____

Employer _____ Work Ph. _____

Person responsible for payment _____

Relationship to patient _____ Home Ph. _____

Spouse (or parent's) name _____

Spouse (or parent's) employer _____

Address _____ Work Ph. _____

Have you ever had root canal treatment? _____

Montgomery
ENDODONTICS, PC
James J. Kamburis, DMD

American Association of Endodontists
Specialty Member

MEDICAL HISTORY

1. Check any of the following which applies to you:

- ❑ High blood pressure
- ❑ Heart Problems:
  - ❑ Mitral valve prolapse (MVP)
  - ❑ Heart murmur
  - ❑ Heart valve replacement
  - ❑ Heart surgery
  - ❑ Heart attack
  - ❑ Pacemaker
- ❑ Rheumatic Fever or Rheumatic Heart Disease
- ❑ Artificial Joint Replacement:
  - ❑ Hip
  - ❑ Knee
- ❑ Blood Thinners
  - What kind? _____
- ❑ Pregnant
- ❑ Hepatitis (A, B, C)
- ❑ Tuberculosis (T.B.)
- ❑ HIV Positive
- ❑ Thyroid Problems
- ❑ Liver Disease
- ❑ Diabetes
- ❑ Lung Disease
- ❑ Asthma
- ❑ Kidney Disease
- ❑ Chemotherapy
- ❑ Epilepsy or Seizures
- ❑ Fainting Spells
- ❑ Organ Transplants
- ❑ Bleeding Disorder

2. ARE YOU ALLERGIC TO:

- ❑ Aspirin
- ❑ Penicillin
- ❑ Local Anesthetic
- ❑ Codeine
- ❑ Latex
- ❑ Tylenol
- ❑ Epinephrine
- ❑ Other. Please List: _____

3. Please list all medications you are currently taking.

_____

_____

4. If you are female, are you currently pregnant? ❑ Yes ❑ No
(Antibiotics may alter the effect of oral contraceptives.
If antibiotics are prescribed, you may need to consult your physician.)

5. Are you currently being treated by a physician? ❑ Yes ❑ No
If so, please explain. _____

_____

6. Have you had any surgery in the past two years? ❑ Yes ❑ No
If so, please explain. _____

_____

7. Do you premedicate before dental treatment? ❑ Yes ❑ No

8. If you premedicate, what do you premedicate for? _____

9. General Physicians Name _____
Phone _____

OFFICE PAYMENT POLICY

IF YOU HAVE DENTAL INSURANCE

Please help us with your claim by completing the following:

Insured person's name _____

Address _____

_____

Birth date _____ Soc. Sec. # _____

Relationship to patient (spouse, parent, etc.) _____

Employer's Address _____

_____

Employer's Phone _____

Name of Plan _____

Group Number _____

Contract Number _____

This is a referral practice, and a mutual respect to obligations is essential to permit our business to be conducted on an efficient and friendly basis. Therefore, to avoid misunderstandings concerning payment of accounts, please note that endodontic treatment is usually completed in one visit and must be paid in full. We will be happy to file insurance claims for you at no extra charge, if the insurance company will also issue a check payable to the dentist. In addition, you must provide our office staff proper information (Dental Insurance Card, Social Security # and Date of Birth of the person you are filing dental insurance under). The estimated difference that the insurance does not pay must be paid the day of the office visit.

Your insurance is a contract between you as a subscriber, and the insurance company as insurer, involving our office, Montgomery Endodontics, P.C. only indirectly. Therefore, any controversy which might arise over your insurance company's handling of your claim is for you to resolve. Any discrepancy between the insurance company's allowance and your total indebtedness remains your responsibility. Any insurance claim that has not been paid within 30 days of treatment will be billed back to you

Any credits to your accounts that may arise, may take up to 90 days. _____

A finance charge of 1 ½% per month will be applied to all accounts over 30 days old. Once insurance payment has been received account must be settled within 30 days. A $30 stop payment fee will be issued for refund check that has to be reissued for any reason.

Montgomery Endodontics, PC does not accept personal checks.

( ) I have dental insurance

( ) I will pay by cash

( ) I will charge to MasterCard_____ Visa _____ Discover ___

( ) I will apply for Care Credit or other third-party financing

I hereby assign, transfer, and set over to Montgomery Endodontics, P.C. all rights, title and interest to my dental reimbursement benefits under my insurance policy, I authorize the release of any dental information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand I am financially responsible for all charges for my dependents, or myself whether or not they are covered by insurance. I, the undersigned, hereby agree that, in the event of default in the payment of any amount due, and if this account is placed in the hands of a collection agency or attorney for collection or legal action, to pay an additional charge equal to the cost of collection including collection agency and attorney fees and court costs incurred. I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including and/all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary.

I, the undersigned, give express prior consent to Montgomery Endodontics, P.C. its employees and/or its agents to contact me at any phone numbers given, including cell phone numbers, for the purpose of treatment, insurance, and/or payment of account.

_____

SIGNATURE OF RESPONSIBLE PARTY

_____

DATE

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Telephone Consumer Protection Act (TCPA):

You agree, in order for us to service your account or to collect monies you may owe, Montgomery Endodontics P.C., and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages/ or use of automatic dialing device, as applicable.

I, the undersigned, give express prior consent to Montgomery Endodontics, P.C. its employees and/or its agents to contact me at any phone numbers given, including cell phone numbers, for the purpose of treatment, insurance, and/or payment of account.

_____

SIGNATURE OF RESPONSIBLE PARTY

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DATE

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ENDODONTIC INFORMED CONSENT

Informed consent advises patients of the general nature of treatment, the medical acceptable alternatives, and the substantial risks inherent in the proposed procedures. In signing this consent form, you are agreeing that you have been advised of these matters to your satisfaction and understand that one alternative is not to have any treatment at all with a full understanding of the risks and hazards of declining treatment.

ENDODONTICS. *Endodontics (root canal) therapy is performed in order to try to save a tooth which otherwise would need to be removed. The word "endodontics" comes from "endo" meaning inside, and "odont" meaning tooth. The actual procedure involves removing inflamed, infected, or damaged tissue from inside the tooth, and cleaning, filling, and sealing the remaining space. Conservative root canal therapy, or when needed, endodontic surgery, accomplishes this. Multiple treatment appointments are usually required.*

OTHER TREATMENT CHOICES. *These include: 1) no treatment, 2) waiting for more definite development of symptoms, or 3) tooth extraction. Risks involved in these choices may include pain, infection, swelling, loss of teeth, and infection to other areas.*

ENDODONTIC EXAMINATION. *Endodontic diagnostic testing in conjunction with radiographic interpretation attempts to isolate the inflamed, infected, or damaged tooth or teeth.*

RISKS OF DENTISTRY. *Included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesic (pain killers), anesthetics, injections of anesthesia, irrigation media, and dental materials. These complications include: sensitivity, swelling, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is transient but on infrequent occasions may be permanent, spasms, temporomandibular (jaw) joint difficulty, loosening of teeth, referred pain to ear, neck, and head, nausea, vomiting, allergic reactions, delayed healing, sinus perforations, and treatment failure.*

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY. *Included (but not limited to) are additional/alternate tooth or teeth requiring endodontics, sterile instruments separating and remaining within the root canal, perforations (extra openings) of the crown or root of the tooth, damage to bridges, existing fillings, crowns, or porcelain veneers, loss off tooth structure in gaining access to canals, over-extension or under-extension of root filling material, and cracked teeth. During treatment complications may be discovered which make treatment impossible, or which may require dental surgery extraction. The complications may include: blocked canals due to fillings or prior treatment, natural calcifications, separated instruments, curved roots, periodontal disease (gum disease), tissue lesions, resorption, and fractures of the teeth.*

X-RAYS. *A series of X-rays is required for endodontic treatment.*

MEDICATIONS. *Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives, or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effects. Antibiotics may inhibit the effectiveness of birth control pills.*

CONSENT. *I, the undersigned, being the patient (parent or guardian of above minor patient) consent to the procedures decided upon to be necessary or advisable in the opinion of the doctor. I also understand that upon completion of root canal therapy in this office, I shall return to my general family dentist for a permanent restoration of the tooth involved (such as a crown or filling) within several weeks.*

I understand root canal treatment is an attempt to save a tooth, which may require extraction if a tooth infection does not resolve. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery, or even extraction.

_____

SIGNATURE OF RESPONSIBLE PARTY

_____

DATE

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Attention Patient

Not all teeth are able to be treated with a root canal and may need to be extracted. Calcified canals, obliterated canals, obstructions, decay, and cracked teeth are just a few issues encountered during treatment. If we encounter any issues that we deem your tooth not treatable, an incomplete code of D3332 will be charged in place of a D3330 (root canal), and we will advise you of your next course of action.

Note: Not all insurances cover this code. Please check your insurance.

Signature _____

Date _____