3715 Bloomington St, STE 160 Colorado Springs, CO 80922 • 3236 Centennial Blvd Colorado Springs, CO 80907
1-866-524-0824 • www.ColoradoEndodonticGroup.com

Patient Information

Name: _____
Last First Middle

E-Mail Address: _____ Gender: Male_____ Female_____

Cell Phone: (____)_____ Home Phone: (____)_____ Work Phone: (____)_____

Home Address:_____
Street City State Zip

Date of Birth: ___/___/_____ Social Security Number: _____-____-_____ Driver's License or ID Number:_____
MM / DD / YYYY

Responsible Party Information (If Patient is a Dependent)

Name: _____
Last First Middle

E-Mail Address: _____ Gender: Male_____ Female_____

Cell Phone: (____)_____ Home Phone: (____)_____ Work Phone: (____)_____

Home Address:_____
Street City State Zip

Date of Birth: ___/___/_____ Social Security Number: _____-____-_____ Driver's License or ID Number:_____
MM / DD / YYYY

Dental Insurance Information (Please Provide a Copy of Your Card)

Name of Primary Policy Holder: _____
Last First Middle

Primary Policy Holder's Date of Birth: _____/___/_____ Primary Policy Holder's SS/ Member ID Number: _____-_____-_____
MM / DD / YYYY
Primary Policy Holder's Employer:_____

Insurance Company Name:_____ Group Number:_____ Insurance Company Phone: (____)_____

Insurance Company Address:_____
Street City State Zip

Emergency Contact Information

Local Friend or Relative not Living With You: _____ Emergency Contact Phone: (____)_____

Emergency Contact Address:_____
Street City State Zip

FOR ALL PATIENTS

I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above, and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

_____

SIGNATURE OF RESPONSIBLE PARTY **RELATIONSHIP TO PATIENT** **DATE**

COLORADO ENDODONTIC GROUP

MEDICAL HISTORY – Please Answer ALL Questions

Name:_____ **Date of Birth:**_____ **Age:**_____

Gender: Male / Female **Height:** _____**ft.** _____**in.** **Weight:**_____ **lbs.**

Primary Care Physician:_____ **Phone/Contact:**_____

1. Do you consider yourself a healthy person? ……❑ Yes ❑ No
2. Have you been under the care of a medical doctor during the past two years? ……❑ Yes ❑ No
   If yes, for what reason?_____ Est. Last Physical Exam Date:_____
3. Do you consider your teeth, gums and mouth to be healthy and problem free? ……❑ Yes ❑ No
4. Do your gums bleed at any time? ..... ❑ Yes ❑ No
5. Are you allergic to (i.e., itching, rash, swelling or hands, feet or eyes) or
   made sick by penicillin, aspirin, codeine, or any drugs or medications? ..... ❑ Yes ❑ No
   If yes, please list._____
6. Have you ever had excessive bleeding requiring special treatment? ……❑ Yes ❑ No
7. Women: Are you or might you be pregnant? …… ❑ Yes ❑ No Estimated Due Date_____
8. Check any and all of the following which you have a history of or currently under treatment for:

❑ Heart Disease or Attack	❑ Ulcers	❑ HIV Positive (AIDS)
❑ Tuberculosis (TB)	❑ Shortness of Breath	❑ Cancer or Tumor
❑ Asthma	❑ Hepatitis (circle: Type A, B or C)	❑ High Blood Pressure
❑ Rheumatic Fever	❑ Liver Disease	❑ Heart Murmur/Mitral Valve
❑ Scarlet Fever	❑ Diabetes	❑ Bruise Easily
❑ Artificial Heart Valve	❑ Thyroid Disease	❑ Drug Addiction
❑ Heart Pacemaker	❑ Chemotherapy (Cancer, Leukemia)	❑ Hemophilia
❑ Heart Surgery	❑ Arthritis	❑ Cold Sores or Fever Blisters
❑ Artificial Joint	❑ Cortisone Medication	❑ Epilepsy or Seizures
❑ Stroke	❑ Glaucoma	❑ Nervousness
❑ Kidney Trouble	❑ Pain in Jaw Joints	❑ Psychiatric Treatment

Do you have or have history of any surgery, disease or medical condition not listed on this form? .....❑ Yes ❑ No

Please list:_____

_____

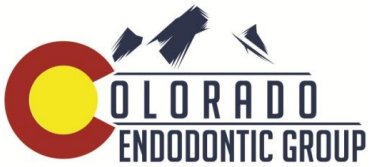
9. List all Prescription Medications you are taking at this time. ❑ None _____

_____

10. Do you use any type of tobacco product regularly? ..... ❑ Yes ❑ No
11. Do you use or have you ever used recreational drugs?.....❑ Yes ❑ No

Signature: _____ **Date:** _____

Updates (date & initial) _____ _____ _____ _____ _____ _____ _____



DENTAL INSURANCE POLICY

Colorado Endodontic Group works with a variety of dental insurance plans. We file all dental insurance claims as a patient courtesy. In the event of a treatment plan, we create a reasonable estimate of patient co-payments and insurance contributions. This estimate is based on contracted insurance rates, the general breakdown of benefits obtained through the insurance verification process and our knowledge of common insurance exclusions. **This estimate is not a guarantee of insurance payment**. **All benefit determinations are at the discretion of the insurance company and are not determined until after a claim is submitted.** We provide treatment estimates as a courtesy in order to minimize the total out-of-pocket cost due by patient. **All estimated patient co-payments are due on or before time of service.**

Patient is responsible for any remaining account balance resulting from insurance nonpayment or underpayment. A statement will be mailed to you regarding this balance. Payment is due immediately upon receipt.

----------PATIENT ACKNOWLEDGMENT AND AUTHORIZATION----------

I understand and agree to the Dental Insurance Policy stated above. I authorize all my insurance companies to make payment directly to Colorado Endodontic Group. This assignment will remain in effect unless revoked by me in writing. I understand I am financially responsible for all charges whether or not paid by said insurance company. Further, I authorize the release of any patient information necessary to process these claims.

Signature: _____ Date: _____

CANCELLATION POLICY

Colorado Endodontic Group makes an effort to see patients on time in order to give patients they care they deserve. Therefore, we ask that you **please give 48 hours notice if you are unable to keep your scheduled appointment**. **We reserve the right to charge a cancellation fee of $50.00 in the event of two (2) or more missed appointments lacking proper notice.** We will make exceptions in the event of reasonable emergencies.

I understand and agree.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICES

I, _____, have had the opportunity to review Colorado Endodontic Groups Notice of Privacy Practices (the entire legal notice is displayed at the front desk).

Signature: _____ Date: _____

Consent to Perform Endodontics

The doctor has explained his diagnosis and has advised me that in his opinion root canal treatment is indicated. The doctor has advised me that in his opinion the consequences of not treating this condition include but are not limited to: worsening of the disease, infection, cystic formation, swelling, pain, loss of tooth, and/or other systemic disease manifestations. The doctor has advised me of alternate treatments, benefits, and risks which include but are not limited to: extraction of affected tooth (teeth) or no treatment or referral to a specialist (endodontist). I, however, believe that the root canal as noted would be my preferred choice of treatment.

The doctor has advised me that there are certain risks and potential consequences of any treatment and such risks would include but are not limited to:

- A certain percentage, approximately 5-10%, of root canals fail necessitating retreatment, root surgery, or extraction.
- Post operative discomfort, swelling, restricted jaw opening which may persist for several days or longer.
- Breakage of root canal instrument during treatment which may, in the judgment of the doctor be left in the treated root canal or require surgery by a specialist for removal.
- Perforation of root canal with instruments which may require additional surgical corrective treatment by a specialist or result in loss of tooth.
- Premature loss of tooth due to progressive periodontal gum disease.
- Root canal treatment relies heavily on radiographic information. Since radiographs are essentially two dimensional shadows which provide reliable but not infallible information, this may lead to root canal failures.
- Successful completion of the root canal procedure does not prevent further decay or fracture. The endodontically treated tooth will be more brittle and may discolor.
- In most cases, a crown and post filling is recommended after completion of the root canal to prevent fracture and/or improve esthetics.

I understand that by the very nature of the proposed treatment and uniqueness of myself as an individual, that no one can predict the certainty of any outcome or success and that even in the event of root canal treatment, my condition may worsen. I understand that no guarantees or assurances have been given to me and that the proposed treatment(s) or alternatives, if any, would satisfy fully my expectations. I believe that it is in my own best interests to proceed with root canal treatment.

I have had ample opportunity to ask questions about root canal therapy, alternatives, and risks and I discussed with the doctor and my medical and health history indicated problem(s), illnesses, and/or allergies.

I certify that I have read, discussed, and fully understand the authorization for root canal therapy. I accept the risks of substantial harms if any in hopes of obtaining the desired beneficial results of root canal therapy.

Patient Signature:_____Date:_____

Witness Signature:_____Date:_____

Doctor Signature:_____Date:_____