ROOT CANAL CENTER OF NAPLES

Dr. Christopher Widmer, D.D.S

Patient Information

Date: _____
Name: _____ Responsible Party: _____
Address: _____ City: _____ State: _____ Zip: _____
Billing Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Business Phone: _____ Cell: _____
Social Security #: _____ Date of Birth: _____
Occupation: _____ Employed By: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated
Spouse Name: _____ Spouse Cell #: _____
Spouse's employer: _____ Spouse's business #: _____

Confidential Medical History

Age: _____ Sex: _____ (if female, are you pregnant?) ☐ Nursing ☐ Obstetrician
Name of physician: _____ City: _____ Phone #: _____

Date last seen: _____ Are you under a physician's care now? ☐ yes ☐ no
If yes, for what condition: _____
Medications you are taking: _____
_____

Are you taking any herbal remedies: ☐ yes ☐ no (if yes, what: _____

Have you been hospitalized in the last two years: ☐ yes ☐ no if yes, for what: _____
_____

Are you allergic to: ☐ Penicillin ☐ Codeine ☐ Local Anesthetic
Are you allergic to any other medications or substances: _____

(Please check any of the following which you have ever had)

__HIV	__High Blood Pressure	__Heart Disease	__Rheumatic Fever
__Stroke	__Thyroid Disease	__Anemia	__Low Blood Pressure
__Heart Murmur	__Hepatitis	__Jaundice	__Kidney Disease
__Asthma	__Artificial Joints	__Artificial Heart Valve	__Radiation Therapy
__Tuberculosis	__Bleeding Disorders	__Diabetes	__Epilepsy
__Cancer	__Chemical Dependency	__Chemotherapy	__Venereal Disease
	__Migraine Headaches		__Sinusitis

Is there any other health information which we should know about? _____
_____
How do you evaluate your overall health: _____
Name of person to contact in case of an emergency: _____

Relationship to patient: _____ Emergency contact's phone #: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent:
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.

Notice of Privacy Practices:
You have the right to read our Notices of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations of the uses and discloses we may make of your protected health information and of other important matters about protected health information. A copy of our notice accompanies this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practice which will contain the changes, those changes may apply to any of our protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice at any time.

Right to revoke:
You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received you revocation and that we may decline to treat you or to continue treating you if you revoke this consent.

By signing this form you are giving consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations and had the opportunity to read and consider the contents of this consent form and our Notice of Privacy Practices.

_____ _____
Patient Signature Date

If this consent is signed by a personal representative on behalf of a patient, complete the following:

_____ _____
Personal Representative Name Relationship to Patient

Dental Insurance Information

Please complete the following required information:

Employer name: _____ SS#: _____ DOB: _____

Employer/ Group Name: _____

ID Number: _____ Group #: _____

Insurance Company Address: _____ State: _____ Zip Code: _____

Insurance Phone #: _____

Financial Policy

The amount of benefits paid by your insurance company is determined by the terms of your policy. Please remember that the insurance contract is between you and your insurance company. You are responsible for payment of the deductible and your estimated portions of all fees when services are rendered. Our office is unable to negotiate any dispute you may have with your insurance company regarding the amount of benefits paid on you claim. **Payment of your account is your responsibility.**

Please read and sign the following:

I have read and understand this form and agree that I am financially responsible for all fee incurred at this office. I authorized the release of all information needed for processing claims to my insurance company and their representatives. I authorize payment directly to Florida Root Canal Specialists of insurance benefits otherwise payable to me.

Patient Name: _____

Patient Signature: _____ Date: _____

Financial Policy / Insurance

The first appointment with Root Canal Center of Naples includes an evaluation and treatment, if needed. There is an evaluation fee, which is due and payable at time of visit.

If you have dental insurance, please let us know, as a service to you we are happy to file a claim with your insurance company on your behalf, but we may need a copy of your insurance card to do so. Our experience has been that most standard dental plans may end up covering up to 100% of the cost of treatment, which will be reimbursed to you by your insurance company. This will be explained to you before treatment is initiated. All fees are payable at the time of service. We will provide you with a statement of services rendered.

Although we have eliminated billing in this office, we do offer a payment plan option which provides up to six months of interest free credit, if you qualify. If you are interested in this option, please inquire at our front desk.

Please read and sign the following:

- I have completed this form to its entirety and certify that I am the patient, legal guardian, or authorized agent of the patient.

- I understand that even though I have some form of dental coverage, I am responsible for the payment of the endodontic services rendered by Root Canal Center of Naples. And that payment is due at time of service.

_____ _____

Patient Signature Date

_____ _____

Legal guardian or authorized agent Date

INFORMED CONSENT FOR ROOT CANAL THERAPY

Brief Explanation of Endodontics: Endodontics treats the soft tissue inside the tooth called the pulp. Endodontic Therapy (Root Canal) is necessary when the pulp of a tooth becomes inflamed or infected, which may result from deep decay, a cracked or chipped tooth, broken or loose filling, a blow to the mouth which damage the pulp, or extensive dental procedures on a tooth.

Recommend Treatment: The recommended treatment for damaged or diseased pulp is root canal therapy. Under local anesthesia, an opening is made into the middle of the tooth and the pulp tissue is removed from the root canals. The canal spaces are then smoothed, filled and sealed. The expected benefit is to prolong the life of the tooth. The success rate is over 90 percent.

Risk of Treatment: Risk include, but are not limited to, the following: cyst formation, acute or chronic infection, separation of the delicate instruments used within the canal, chronic biting sensitivity, and root fracture. Root canal treatment does not change the chances for gum disease or new decay.

Alternatives to this treatment:

1. It is possible to live with a chronic infection. However, this would be unhealthy. If your resistance decreases, the infection from around the roots could travel to other parts of your system, causing potentially serious problems.
2. Extraction of your tooth would solve the problem.

Other Considerations: There is no guarantee that root canal therapy will be successful. We make every effort to treat you according to the most modern and scientific methods and follow CDC Guidelines for the prevention and spread of infection. There is a possibility if your tooth has an existing crown that the porcelain may chip or crack and will need to be repaired or replaced by your general dentist.

Financial Consideration: Full payment is required at the time of treatment, unless you have insurance that we are contracted with. We are happy to quote our current fees prior to treatment. If insurance is involved you will pay your percentage at that time. If there is any balance that the insurance does not pay, you are responsible for the balance. If not received within 45 days after insurance payment the account will be sent to collections.

Following root canal treatment: It is your responsibility to have your tooth restored with a "permanent" filling or crown by your regular dentist after root canal treatment. A crown is usually required.

By your signature below, you affirm that you have read and understand the information provided in this form, or have had it explained to you. Further, you understand that endodontic treatment is not guaranteed. You have been advised that you may need to see your regular dentist for "permanent" restoration, usually a crown (cap), following your root canal. Your consent to endodontic therapy, by the endodontist who treats you, is given freely and you acknowledge your responsibility for all fees incurred at this office, and to continue regular dental care with your dentist.

Patient Signature: _____ Date: _____

Legal Guardian/Power of Attorney: _____ Date: _____

Must Complete if under 18
Responsibility Party Information

Mother's name: _____

SS#: _____ Date of Birth: _____

Address: _____

Phone #: _____ Alt #: _____

Employer: _____ Occupation: _____

Work phone #: _____

Father's name: _____

SS#: _____ Date of Birth: _____

Address: _____

Phone #: _____ Alt #: _____

Employer: _____ Occupation: _____

Work phone #: _____