CAPITAL ENDODONTICS

Child Registration Form

Last Name _____ First Name _____ MI _____

Date _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Email Address _____

Parent(s) Name(s) _____

Primary Insurance

Person Responsible for Account _____ Relationship to Child _____

Social Security No. _____ Date of Birth _____

Address (if different from child) _____

Employer _____ Work Phone _____

Employer Address _____

Insurance Company _____

Insurance Address _____

Group #_____ Insurance Phone_____

Additional Insurance

Person Responsible for Account _____ Relationship to Child _____

Social Security No. _____ Date of Birth _____

Address (if different from child) _____

Employer _____ Work Phone _____

Employer Address _____

Insurance Company _____

Insurance Address _____

Group #_____ Insurance Phone_____

CAPITAL ENDODONTICS

Health Information

Patient Name _____ Date of Birth _____

Name of Referring Dentist _____

Are you currently taking any drugs and/or medications? ◯ Yes ◯ No
If yes, please list:

_____

_____

Are you under medical treatment now other than dental treatment? ◯ Yes ◯ No
If so, please explain

_____

Have you ever been hospitalized, had a major operation or serious illnesses? ◯ Yes ◯ No
If so, please explain

_____

Are you allergic to any of the following?

___ Anesthetics
___ Penicillin
___ Codeine
___ Rubbing alcohol
___ Latex
___ Metals
___ Bleach
___ Pain medications
___ Fluoride
___ Iodine
___ Other medications

Please include any items not specified above: _____

Do you presently have, or have you ever had any of the following? (Please check all that apply)

___ Heart attack
___ Heart ailment or disease
___ Heart murmur
___ Pacemaker
___ Stroke
___ Poor blood clotting
___ Blood transfusion
___ Mental depression
___ Epilepsy
___ Drug abuse/addiction
___ High blood pressure
___ Heart valve implant
___ Mitral valve prolapse
___ Angina (chest pain)
___ Artificial joints/prosthesis
___ Tumors or growths
___ Radiation treatments
___ AIDS or HIV
___ Panic attacks
___ Seizures
___ Alcohol abuse/addiction

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___ Asthma
___ Blood disease
___ STD/STI
___ Intestinal disease
___ Hemophilia
___ Other _____
___ Liver disease
___ Respiratory disease
___ Other _____
___ Diabetes
___ Tuberculosis
___ Anorexia/bulimia
___ Chemotherapy
___ Stomach disease
___ Hepatitis

Are you pregnant? ◯Yes ◯No
If so, your expected due date is _____

I certify that the information that I have provided is complete and accurate. I understand that it is my responsibility to notify this dental office of any changes prior to initiating any dental treatment.

We will have you sign this form upon check in for your appointment.

Patient Signature _____ Date _____

Health Information Update

Date _____ No Updates _____ Updated _____

Date _____ No Updates _____ Updated _____

Date _____ No Updates _____ Updated _____

Date _____ No Updates _____ Updated _____

Date _____ No Updates _____ Updated _____

Date _____ No Updates _____ Updated _____

Date _____ No Updates _____ Updated _____

CAPITAL ENDODONTICS

Acknowledgement of Financial Policy

We are always available to help patients with billing, insurance and payment questions. We accept most insurance plans and our billing department is happy to assist you in determining what, if any, coverage is available to you in advance of your appointment. Please read below for more detailed information.

We gladly accept most insurance plans, except health/dental discount cards, Medicare or Medicaid. Our office offers in-network plans with American Dental Plan, Momentum, Delta Dental PPO, Cigna Dental PPO and Humana Dental PPO; as well as a non-plan agreement with Dean Health Plan. Coverage levels will depend on a patient's specific plan and policy.

Patients without insurance: For patients who do not have insurance or are not billing any portion of their service through an insurance provider, we offer a 5% discount with a check or cash payment and a 3% discount for credit or debit card payments.

Patients with insurance: As a courtesy, we will look into your insurance benefits to help determine what coverage you have at our office and what your ***estimated*** patient portion will be. The estimated patient portion is due the day of service, and is not subject to the discount. We will process and submit insurance claims, and we understand that most involve some delay in payment. If your insurance company does not render its portion within 45 days, the balance is your responsibility and is due within 30 days of receipt of our billing statement.

Payment Plans/Financing: Our payment plan option is Care Credit, a financing company that offers 6 or 12 months interest free for amounts $200 and above. You must apply for Care Credit ***before*** your appointment as we are unable to apply for you in office. For more information, please feel free to ask our front office staff.

Refund Policy: If a patient's insurance company pays more than we anticipate, a refund check for the amount of the overage will be issued to the patient or guarantor (if patient is a minor) of the account. If a patient requests a partial or full refund for any other reason, that request is handled on an individual basis between the providing doctor, the patient and our office staff.

Noncompliance: Noncompliance with this policy may result in the assessment of late charges and/or your account being sent to a collection agency. We are always happy to answer any questions you have about fees and billing prior to initiating any scheduled treatment.

I understand and accept the terms of the financial policy outlined above.

Patient Name (please print) _____

Patient Signature _____ Date _____

Parent/Guardian Name _____
(for patients under 18 years of age)

Parent/Guardian Signature _____ Date _____
(for patients under 18 years of age)

CAPITAL ENDODONTICS

Notice of Privacy Acknowledgement

2418 Crossroads Dr., Ste. 2900 Madison, WI 53718 • 8333 Greenway Blvd., Ste. 380 Middleton, WI 53562

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand the Notice of Privacy Practices which contains a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at anytime at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Patient Signature: _____

Date: _____

Relationship to Patient: _____
(if you are accompanying a minor or have power of attorney)

If you'd like your spouse or other family member to have access to your files, please fill in below:

I, _____ authorize _____
to have access to my medical and/or financial records at Capital Endodontics.

Patient Signature _____ Date _____

CAPITAL ENDODONTICS

Patient Consent for Endodontic Procedures

This document briefly explains endodontic (root canal) treatment including some of the risks and benefits. Please read the following paragraphs and feel free to discuss any aspect of your treatment. Upon completion, please sign at the bottom where indicated. I agree to and understand the following:

- Root canal treatment is a procedure that allows one to keep a tooth that might otherwise have to be removed. An endodontic examination is performed to determine the specific need for root canal treatment. Root canal treatment involves making an opening in the tooth to remove damaged soft tissue that runs through the root. This space of tissue is then cleansed, disinfected, and sealed with dental filling material. Root canal treated teeth generally act and feel just like other teeth and may have an excellent chance of remaining in the mouth for as long as other teeth.

- Despite the high success rate of root canal treatment, as with any branch of medicine or dentistry, no guarantee of success can be given. On occasion, a tooth that has received root canal treatment may require additional treatment or extraction at additional fees.

- If a patient chooses not to proceed with root canal treatment, there is risk of increasing pain, infection, bone and tissue destruction, and extraction. Removal of a tooth may require other types of dental procedures at additional fees.

- Re-treating a previous root canal or treating a root canal started in other dental offices may have different outcomes. There is no guarantee of success.

- Possible complications encountered during root canal treatment include but are not limited to:
    - Curved canals, curved roots
    - Paresthesia or anesthesia of associated nerve tissue
    - Crown or root fracture (tooth cracking)
    - Calcification (narrowing) in root canal space
    - Pain during or following treatment
    - Swelling or discoloration of the soft tissue (gum tissue) or hard tissues (tooth)
    - Procedural difficulties such as instrument breakage, root perforation (artificial hole in the tooth), or overextension of the filling material beyond the confines of the tooth root

- Following treatment, tenderness in the area is common for 48-72 hours. Some cases require even more time for symptoms to subside.

- Periodic re-evaluation of the tooth is recommended following the completion of the root canal.

- After root canal treatment the new filling or crown must be placed. Failure to do so increases the risk of crown or root fracture which could result in extraction of the tooth.

- I understand that some medications, drugs, anesthetics, and prescriptions taken for this procedure may cause drowsiness and lack of awareness and coordination. I further understand that these drugs and anesthetics may cause unanticipated reactions, which might require medical treatment. I also understand that alcohol or other drugs can increase these effects. I have been advised not to operate any vehicle or machinery until I have fully recovered from the effects of these medications.

I understand that after root canal treatment I will need to return to my dentist for a new filling or crown. The root canal treatment fee does not include cost for the filling, crown, or fees for periodontal (gum) treatment.

Patient Signature _____ Date _____