EXTON ENDODONTICS
WEST CHESTER ENDODONTICS
PAOLI ENDODONTICS
BRYN MAWR ENDODONTICS

Date: _____

MR. MRS. MISS. MS. DR.	LAST NAME	FIRST NAME
HOME PHONE ( )	CELL PHONE ( )	
EMAIL ADDRESS		
HOME STREET ADDRESS		
CITY	STATE	ZIP
DATE OF BIRTH / SEX	HEIGHT	WEIGHT
OCCUPATION	WORK PHONE ( )	
REFERRED BY		
SOCIAL SECURITY #	DENTAL INSURANCE COMPANY NAME	
PHYSICIAN	PHONE ( )	

1. Do you have or have you had any of the following? (Please circle)

a. Rheumatic fever
b. Congenital heart disease
c. Cardiovascular heart attack, coronary insufficiency, high blood pressure, arteriosclerosis, stroke, coronary by-pass, and prosthetic valve
d. Abnormal bleeding
e. Asthma, hay fever, sinus trouble
f. Hives or a skin rash
g. Veneral disease
h. Diabetes
i. Hepatitis, jaundice or liver disease
j. Stomach ulcers
k. Kindney trouble
l. Tuberculosis, lung disease
m. Fainting spells, seizures or epilepsy
n. Temporomandibular joint problems
o. Psychiatric treatment
p. Acquired immune deficiency syndrome (AIDS)
q. Joint prosthesis (hip, etc.)

Other: _____

2. Are you allergic to penicillin, local anesthetics, pain killers or any drugs? ☐ Yes ☐ No

If so, which drugs: _____

3. Has there been any changes in your general health within the past year? ☐ Yes ☐ No

4. Are you now under the care of a physician? ☐ Yes ☐ No

Nature of treatment: _____

5. Do you have a heart murmur? ☐ Yes ☐ No

6. For Medical Reasons, are you required to take antibiotics for dental treatment? ☐ Yes ☐ No

7. Have you had abnormal bleeding associated with previous extractions, surgery or trauma? ☐ Yes ☐ No

8. Have you ever had surgery and/or radiation or chemotherapy for tumor or growth? ☐ Yes ☐ No

9. Are you taking any medication? ☐ Yes ☐ No

If so, name them: _____

10. Do you have any disease, condition or problem not listed above? ☐ Yes ☐ No

11. Date of last physical exam _____

12. (Women): Are you pregnant? ☐ Yes ☐ No

INFORMED CONSENT

This is my consent to the endodontic precedures indicated and any other procedures deemed necessary or advisable as a corollary to the planned endodontic therapy performed by any of the endodontists employed by Exton Endodontics and any assistant they may require. I agree to the use of local anesthesia, sedation, and/or analgesia, depending upon the judgment of the endodontist involved in my case. Complications of root canal therapy and anesthesia may include swelling, discomfort, infection, bleeding sinus involvement, and numbness or tingling of the lip, gum or tongue, which rarely is protracted and even more rarely is permanent.

I understand that root canal therapy is a procedure to retain a tooth which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, results can not be guaranteed. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery, or even extraction. I also understand that only the root canal therapy is to be performed at this office; restoration of my tooth (filling, crown, etc.) will be done by my family dentist. During treatment there is the possibility of instrument breakage within root canals, perforations (extra openings), damage to bridges, existing fillings, crowns, or porcelain veneers, loss of tooth structure in ganing access to canals, and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when my tooth may not be amendable to endodontic treatment at all. Other treatment choices include no treatment, waiting for more definitive symptoms to develop or tooth extraction. Risks involved in these choices might include but are not limited to pain, infection, swelling, loss of teeth, and infections in other areas.

I understand that medications for discomfort and sedation may cause drowsiness which can be increased by the use of alcohol or other drugs. I will avoid operating any vehicle or hazardous devices while taking such medications. I further understand that certain medications may cause hives and intestinal problems and if any of these reactions occur, I am to call the doctor immediately. I understand that it is my responsibility to report any changes in my medical history.

All responsible collection and/or legal costs required to collect fees due Exton Endodontics will be borne by the undersigned.

ALL SIGNATURES MUST BE BY PARENT OR GUARDIAN IF PATIENT IS 18 YEARS OLD OR YOUNGER.

_____ DATE

_____ SIGNATURE

Dental Insurance

Patient's Name: _____ Birthdate: _____
SSN: _____
Subscriber Name: _____Birthdate:_____
Subscriber SSN: _____Relation to Patient: _____
Employed by: _____ Business Phone:_____
Full Business Address:_____
Insurance Co. Name: _____ Insurance Co. Phone: _____
Address to Send Claims: _____
Group Number: _____ ID Number: _____

If there is secondary coverage (through the spouse)

Subscriber Name: _____ Birthdate: _____
Subscriber SSN: _____ Relation to Patient: _____
Employed by: _____ Business Phone: _____
Full Business Address: _____
Insurance Co. Name: _____ Insurance Co. Phone: _____
Address to Send Claims: _____
Group Number: _____ ID Number: _____

As a courtesy to our patients we will provide estimates of insurance payments. This is no way a guarantee of insurance payment. The patient will be responsible for any remaining balance after payment has been received from the insurance company.

What form of payment do you plan on using today?

__ Cash

__ Check

__ Credit Card

Patient signature: _____ Date: _____

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

-Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment):

-Obtaining payment from third-party payers (e.g. my insurance company)

-The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20_____.

Print patient name: _____

Relationship to patient: _____

Signature: _____

Practice Name: Bryn Mawr Endodontics

Address: 135 S Bryn Mawr Avenue, Suite 340, Bryn Mawr PA 19010

Patient Advisory and Acknowledgement

Receiving Dental Treatment During the COVID-19 Pandemic

Dear patient:

You have come to our office today for a routine dental evaluation and/or treatment that will be done during the COVID-19 pandemic. Please be advised of the following:

> While our office complies with the State Health Department and Centers for Disease Control and Prevention infection control guidelines to prevent the spread of the COVID-19 virus, we cannot make any guarantees.
>
> Our staff are symptom free, and, to the best of their knowledge, have not been exposed to the virus. However, since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

In order to reduce the risk of spreading COVID-19, we have asked you a number of "screening" questions below. For the safety of our staff, other patients, and yourself, please be truthful and candid in your answers.

PATIENT/RESPONSIBLE PARTY: _____ DATE: _____

PLEASE ANSWER YES OR NO WITH YOUR INITIALS ON THE FOLLOWING QUESTIONS		
Are you currently awaiting the results of a COVID-19 test?	YES	NO
Do you have a fever?	YES	NO
Do you have any shortness of breath?	YES	NO
Do you have a dry cough?	YES	NO
Do you have a runny nose?	YES	NO
Do you have a sore throat?	YES	NO
Do you have sneezing, watery eyes, and/or sinus pain/pressure that is unusual and not related to seasonal allergies?	YES	NO
Have you experienced headaches, fatigue, or weakness?	YES	NO
Have you lost your sense of taste and/or smell?	YES	NO
Within the last 14 days, have you traveled to any foreign country?	YES	NO
Within the last 14 days, have you traveled within the United States?	YES	NO

If so, where?

COVID-19 PANDEMIC EMERGENCY DENTAL TREATMENT NOTICE AND ACKNOWLEDGMENT OF RISK FORM

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding the COVID-19 virus.

The COVID-19 virus is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

The COVID-19 virus has a long incubation period. You or your healthcare providers may have the virus and not show any symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of the dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures create water spray, which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air for an extended period of time, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your health care providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

I confirm that I have read the notice above and understand and accept that there is an increased risk of contracting the COVID-19 virus in the dental office or with dental treatment. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I could contract the COVID-19 virus from outside this office and it may be unrelated to my visit here.

I have read and understand the information stated above:

_____ _____

Signature Date