CONFIDENTIAL HEALTH RECORD

LAST NAME	FIRST NAME MIDDLE INITIAL (NICKNAME)	☐ MR ☐ MRS ☐ MISS ☐ MS ☐ DR ☐ REVEREND ☐ SISTER ☐ FATHER
HOME ADDRESS	CITY STATE ZIP	
SOCIAL SEC #	BIRTHDATE	EMPLOYER_____ ADDRESS _____
HOME PHONE # ( )	WORK PHONE # ( ) EXT#	CELL PHONE# ( )
SPOUSE NAME	IF CHILD, PARENT'S NAME_____ IF STUDENT, SCHOOL_____ CITY_____	
YOUR GENERAL DENTIST	WHO REFERRED YOU TO OUR OFFICE:	
DENTAL COVERAGE ☐ YES ☐ NO COMPANY NAME _____ ADDRESS_____ _____ GROUP # _____	NAME OF INSURED_____ RELATION_____ INSURED'S SS#_____ BIRTHDATE_____ INSURED'S EMPLOYER_____	

INFORMATION SHEET AND STATEMENT OF OFFICE POLICY

You have been referred to our office for root canal examination, consultation, and treatment as deemed necessary. In order to serve you better and a rrive at a mutually beneficial understanding of your treatment, it is important for you to read and understand the following:

Endodontics is a specialty whose purpose is to relieve pain, eliminate infection and **SAVE TEETH**. Many years of experience and study, including additional training following dental school are required for one to become an endodontist.

Most of our treatment procedures require one or two office visits, then **you will return to your dentist for placement of a final restoration on the tooth.** Our fees will vary depending on the time involved, the difficulty of treatment and the number of root canals contained within the tooth.

In our office we all feel a great deal of responsibility to our patients and strive to do the best work we are capable of doing in serving you. We have, unfortunately, not had a similar response from some of our patients in regards to payment to us for services rendered. We therefore have had no choice but to insist on a full payment by completion of treatment. Should you have dental insurance coverage, we will gladly submit those forms for you and request only a partial payment from you personally on your final visit. We want to emphasize that your insurance is a contract between you and your insurance company, not your insurance company and our office.

Your signature below hereby authorizes our office to affix your name to any and all claims or documents as related to any and all health benefits due for treatment rendered in this office. When necessary, payment due will be directly made to this office. Please review the copy of this office's Notice of Privacy Practices located in the waiting room. Copies will be made available upon request. Signing this form will give consent to use and disclose your protected health inform ation to carry out treatment, payment activities and healthcare operations.

I HAVE READ AND UNDERSTAND THE ABOVE.

_____ _____ _____

Date Signature of Patient *

All signatures must be by parent or guardian if patient is under the age of 18.

PLEASE COMPLETE BOTH SIDES

MEDICAL HISTORY

Physician's name_____
Physician's phone (if known)_____
Has there been any change in your general health within the past year? ☐ YES ☐ NO
Please specify_____
Are you currently under the care of a physician? ☐ YES ☐ NO
Please explain_____
Have you been hospitalized within the past five years? ☐ YES ☐ NO
Reason_____
Are you taking any prescription / over the counter drugs? ☐ YES ☐ NO
Please list_____ _____
_____ _____
_____ _____
Due to health reasons do you take antibiotics before dental treatment? ☐ YES ☐ NO
Have you ever experienced pain / discomfort in your jaw joint (TMJ)? ☐ YES ☐ NO

Please check if are you ALLERGIC to any of the following?

☐ Aspirin	☐ Penicillin	☐ Tetracycline
☐ Codeine	☐ Clindamycin	☐ Sulfa Drugs
☐ Dental Anesthetics	☐ Erythromycin	☐ Latex

Please list any other drugs/materials you are allergic to: _____

Have you ever had any of the following diseases or medical problems?
(PLEASE CHECK)

☐ Abnormal Bleeding	☐ Diabetes	☐ Heart Surgery	☐ Radiation Treatment
☐ Alcohol/Drug Abuse	☐ Difficulty Breathing	☐ Hepatitis	☐ Rheumatic Fever
☐ Anemia	☐ Emphysema	☐ Herpes/Fever Blisters	☐ Shingles
☐ Arthritis	☐ Epilepsy/Seizures	☐ High Blood Pressure	☐ Sickle Cell Disease
☐ Artificial Bones/Joints/Valve	☐ Fainting Spells	☐ HIV+/AIDS	☐ Sinus Problems
☐ Asthma	☐ Frequent Headaches	☐ Kidney Problems	☐ Stroke
☐ Blood Transfusion	☐ Glaucoma	☐ Liver Disease	☐ Thyroid Problems
☐ Cancer/Chemotherapy	☐ Hay Fever	☐ Low Blood Pressure	☐ Tuberculosis
☐ Colitis	☐ Heart Attack	☐ Mitral Valve Prolapse	☐ Ulcers
☐ Congenital Heart Defect	☐ Heart Murmur	☐ Pacemaker	☐ Venereal Disease

WOMEN ONLY:
Are you pregnant? ☐ YES ☐ NO
Are you nursing? ☐ YES ☐ NO
Do you take birth control pills? ☐ YES ☐ NO
(*If yes, be advised that if you take antibiotics, an alternative method birth control must be used)*

FEE MUST BE PAID IN FULL AT THE COMPLETION OF TREATMENT.
WHICH OF THE FOLLOWING METHOD OF PAYMENT WILL YOU BE USING?

☐ CASH ☐ CHECK ☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMERICAN GENERAL OR CARE CREDIT

Office Use Only **MEDICAL HISTORY UPDATE**
Date_____Signature_____Comments_____
Date_____Signature_____Comments_____

NORTH AMERICAN
DENTAL GROUP

Non-Discrimination Policy

North American Dental Group and its affiliates comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. North American Dental Group and affiliates do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

If requested, North American Dental Group and affiliates provide free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

If you need these services, contact the Office Manager at the practice location.

If you believe that North American Dental Group and affiliates have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Kiena P Nutter- Compliance Coordinator
11 S Mill St
New Castle, PA 16101
724.698.2905
nutterk@nadentalgroup.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Kiena P Nutter, Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

ADA Dental Patient Rights and Responsibilities Statement

Your dentist is the best source of information about your dental health and wants you to feel comfortable about your dental care. Maintaining healthy teeth and gums means more than just brushing and flossing every day and visiting your dentist regularly. As an informed dental patient, it also means knowing what you can expect from your dentist and dental care team and understanding your role and responsibilities in support of their efforts to provide you with quality oral health care.

The rights and responsibilities listed below do not establish legal entitlements or new standards of care, but are simply intended to guide you through the development of a successful and collaborative dentist-patient relationship.

Patient Rights

1. You have a right to choose your own dentist and schedule an appointment in a timely manner.

2. You have a right to know the education and training of your dentist and the dental care team.

3. You have a right to arrange to see the dentist every time you receive dental treatment, subject to any state law exceptions.

4. You have a right to adequate time to ask questions and receive answers regarding your dental condition and treatment plan for your care.

5. You have the right to know what the dental team feels is the optimal treatment plan as well as the right to ask for alternative treatment options.

6. You have a right to an explanation of the purpose, probable (*short and long term*) results, alternatives and risks involved before consenting to a proposed treatment plan.

7. You have a right to be informed of continuing heath care needs.

8. You have a right to know in advance the expected cost of treatment.

9. You have a right to accept, defer or decline any part of your treatment recommendations.

10. You have a right to reasonable arrangements for dental care and emergency treatment.

11. You have a right to receive considerate, respectful and confidential treatment by your dentist and dental team.

12. You have a right to expect the dental team members to use appropriate infection and sterilization controls.

13. You have a right to inquire about the availability of processes to mediate disputes about your treatment.

14. You have the right to receive access to treatment and accommodations that are available regardless of race, sex, age, creed, sexual orientation, national origin, religion, handicap, or marital status

Patient Responsibilities

1. You have the responsibility to provide, to the best of your ability, accurate, honest and complete information about your medical history and current health status.

2. You have the responsibility to report changes in your medical status and provide feedback about your needs and expectations.

3. You have the responsibility to participate in your health care decisions and ask questions if you are uncertain about your dental treatment or plan.

4. You have the responsibility to inquire about your treatment options and acknowledge the benefits and limitations of any treatment that you choose.

5. You have the responsibility for consequences resulting from declining treatment or from not following the agreed upon treatment plan.

6. You have the responsibility to keep your scheduled appointments.

7. You have the responsibility to be available for treatment upon reasonable notice.

8. You have the responsibility to adhere to regular home oral health care recommendations.

9. You have the responsibility to assure that your financial obligations for health

Areas within the practice may be limited to some requests for accommodations specifically where facility must maintain a sterile environment.