Kingwood Dental Specialists

Oral Surgery ~ Endodontics ~ Periodontics

NAME_____ Referred to us by_ Parent/Guardian if minor_____

_____

Date of birth_____ ____Single ___Married ____Minor *(under 18)*

Address_____ Apt# _____ Home ph_____

City_____ State____ Zip_____ Cell ph _____

____Male _____Female SS# _____ Email Address

Emergency Contact _____ Relationship _____ Emergency ph

Pharmacy Name _____ Pharmacy Number_____

Please complete all items below for Dental Insurance processing

DENTAL INSURANCE ____None ____Dental Plan PPO

Policy holder_____ Do you have your dental ID card? _____

Date of Birth_____ Are you covered under a 2nd plan? _____

Policy holder SS## _____ Patient relationship to policy holder ___Self ___Spouse ___Dependent

Policy holder Ins. ID#_____

Policy holder employer_____

Insurance company_____ Insurance company ph_____

Group #_____

INSURANCE AGREEMENT

We will gladly file a claim for your services on your behalf as a courtesy and accept assignment of benefit (payment to be sent to the practice) from your insurance company to supplement out of pocket expenses. However, it is important to understand insurance is a contract between you, your employer, and the insurance company. We are not a participant in some of these contracts making our practice **out of network**.
Also, it is your responsibility to notify us of any changes or cancellations in your insurance prior to the start of your appointment.
We recommend treatment based on individual needs and not insurance benefits. We provide you an **estimate** of insurance benefits based on the information available. We **cannot guarantee** the amount your insurance will pay/cover due to many limitations and exclusions in your policy. **Any balance not paid by your insurance is still your responsibility.** If you do not approve of this policy, we are happy to assist you in filing your own insurance claim.

☐ **I understand and acknowledge Kingwood Dental Specialists is out of network with some insurance companies and cannot guarantee the amount my insurance will pay/cover due to many limitations and exclusions in my policy.**

Signature: _____ Date: _____

Consent for Use and Disclosure of Health Information

Health Insurance Portability and Accountability Act

Please read the following carefully.

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 Notice 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 disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available upon request. We encourage you to read it carefully and completely before signing 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 Practices, which will contain the changes. Those changes may apply to any of your 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 by contacting:

1414 Green Oak Terrace Court, Suite 400 77339 281.359.1011 Office 281.358.1085 Fax

Consent

I, _____**(please print)**, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent for your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: X_____**Date: X**_____

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

Personal Representative's Name: _____

Relationship to Patient: _____

Right to Revoke

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

Revocation of Consent

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. **I also understand that you may decline to treat or continue to treat me after I have revoked my consent.**

Signature: _____Date: _____

If a personal representative on behalf of the patient is signing this revocation of consent, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

MEDICAL HISTORY for ENDODONTIC PATIENTS (Root Canal)

ANSWER ALL QUESTIONS. CIRCLE Y (Yes) or N (No)

PRESENT OR PAST CONDITION

Congestive heart failure (CHF) ..... Y N
Heart disease, arteriosclerosis ..... Y N
Angina, chest pain ..... Y N
Previous heart attack ..... Y N
Heart surgery ..... Y N
Congenital heart defect ..... Y N
Heart valve replacement ..... Y N
Pacemaker, palpitations ..... Y N
High blood pressure ..... Y N
Low blood pressure ..... Y N
Rheumatic fever, rheumatic heart problems ..... Y N
Heart murmur ..... Y N
Mitral valve prolapse, other valve problems ..... Y N
Previous stroke, CVA, or TIA ..... Y N
Epilepsy, seizures, convulsions ..... Y N
Fainting spells, dizzy spells ..... Y N
Joint, knee, hip replacement ..... Y N
Kidney disease ..... Y N
Hepatitis/liver disease Type A B C ..... Y N
Thyroid problems, high or low ..... Y N
Diabetes in self, mother, father ..... Y N
Anemia, iron deficiency, sickle cell ..... Y N
Bleeding disorder, hemophilia, bruising ..... Y N
Leukemia or other cancer ..... Y N
Chemotherapy, radiation therapy ..... Y N
HIV, AIDS ..... Y N
STD (sexually transmitted disease) ..... Y N
Alcohol dependency ..... Y N
Prescription drug dependency ..... Y N
Tuberculosis ..... Y N
Tobacco use of any kind ..... Y N
Asthma, bronchitis, chronic cough ..... Y N
COPD, breathing prob, emphysema, pneumonia Y N
Hay fever, seasonal allergy ..... Y N
Sinus or nasal problems ..... Y N
Allergies, rash, hives, throat swelling ..... Y N
Arthritis or inflammatory rheumatism ..... Y N
Stomach ulcers, colitis, IBS ..... Y N
Claustrophobic ..... Y N
Glaucoma, eye diseases ..... Y N
Jaw surgery ..... Y N
Neuralgia, neuritis in head/neck ..... Y N
Osteoporosis, osteopenia ..... Y N
Depressed immune system ..... Y N
Women: Are you pregnant? Nursing? ..... Y N

HAVE YOU USED THE FOLLOWING IN PAST 48 HOURS?

Cocaine ..... Y N
Amphetamines, diet pills ..... Y N
Ecstasy, Methamphetamines ..... Y N
Herbal remedies or herbal stimulants ..... Y N
Energy boosters containing ephedrine ..... Y N
Alcohol, tranquilizers, sedatives ..... Y N

OTHER MEDICAL CONDITIONS NOT LISTED ABOVE:

_____

_____

ARE YOU NOW UNDER THE CARE OF A PHYSICIAN? _____

Name _____
Specialty _____
Conditions treated _____

_____

_____

Recent surgery or hospital stay?

_____

May we request medical information related to your treatment?

CURRENT MEDICATIONS YOU'RE TAKING (List below)

Antibiotics _____ Y N
Pain medication _____ Y N
Oral steroids such as Prednisone _____ Y N
Aspirin therapy, Aleve, Motrin _____ Y N
Blood thinners _____ Y N
Blood pressure meds _____ Y N
Nitroglycerin _____ Y N
Digitalis, Inderal _____ Y N
Cholesterol lowering _____ Y N
Anti-depressants/tranquilizers _____ Y N
Insulin, diabetes _____ Y N
Antihistamines _____ Y N
Birth control pills _____ Y N
Asthma meds or inhalers _____ Y N
Epilepsy/seizure meds _____ Y N
Thyroid meds _____ Y N
Fosamax, Actonel, Boniva or other osteoporosis meds ... Y N
Zometa, Reclast, Aredia, Prolia or other IV cancer meds Y N
Other meds or herbal remedies ..... Y N

_____

HAVE YOU HAD AN ADVERSE REACTION TO:

Dental anesthetic (Novocain) ..... Y N
Latex or Rubber ..... Y N
Aspirin or Ibuprofen ..... Y N
Penicillin, Cephalosporin, or other antibiotic ..... Y N
Codeine, Vicodin (Hydrocodone)..... Y N
Sedatives, tranquilizers, barbiturates ..... Y N
Sulfa drugs ..... Y N
Iodine, metals, chemicals ..... Y N
Foods ..... Y N
Other drug reactions _____

DO YOU PREFER NITROUS OXIDE/OXYGEN (laughing gas) FOR TREATMENT? ____Yes ____No (There is a fee for this service)

NAME _____

Date of Birth ____/____/_____ **___Male ___Female**

Referred By Dr. _____

_____ _____

Patient Signature **Date**

(Guardian/parent sign for patient under 18)

For Office Use:

Reviewed by _____ *Date* _____
Updated by _____ *Date* _____

Endodontics Informed Consent for Treatment
Kingwood Dental Specialists

This is my consent to perform any necessary dental procedures as indicated by my examination which may include, but are not limited to: diagnostic procedures, treatment procedures, use of local anesthetics and sedation with Nitrous Oxide/Oxygen. Every effort has been made to reduce the risks associated with treatment.

_____ I understand that although root canal therapy has a high degree of success, it is a biological procedure and has no guarantee of success. Occasionally, a tooth which has been treated by root canal therapy may need re-treatment, surgery, or even extraction.
____ I understand that re-treatment cases or mid-treatment cases (started by another dentist) are more difficult, more prone to complications, and may have a lower success rate.
____ I understand that there are alternatives to root canal therapy or re-treatment root canal therapy which include: no treatment at all, extraction of the tooth with no replacement or replacement with a bridge, partial denture or implant.
____ I understand that the permanent restoration (filling or crown) will be done by my general dentist following root canal treatment. Failure to restore the tooth properly could result in fracturing and loss of the tooth. Follow-up exams and x-rays may be needed to follow the healing of treated teeth.
____ I understand that the injection of local anesthetics may result in soreness, swelling, bruising, and occasionally temporary or permanent numbness of the area injected. For some patients, medications in the injection may cause an increase in heart rate, irregularities in heart rate, or difficulty breathing.
____ I understand that there are certain inherent and potential risks in any treatment procedure. These include:

Pain, swelling, fever or infection may be present after treatment.
Limited jaw opening for treatment may result in short term muscle or jaw pain.
Fracture of existing tooth structure, fillings, crowns, or bridges may occur during treatment.
Calcified, curved canals may complicate treatment resulting in the root canals being blocked, ledged, or perforated; or the possibility of broken instruments.
Slight overfills or underfills of sealer or filling material may occur.
Existing multiple pain patterns may require initial treatment plus additional treatment to alleviate pain symptoms.
Cracked tooth syndrome: Undetectable by x-ray examination, the majority of cracks occur in the crown portion of the tooth and can be saved with root canal therapy and full crown restoration. Cracks of the root portion of the tooth can affect healing and may result in continued chewing pain and eventual extraction.

____ I understand that I will have an opportunity to ask the endodontist questions and have them answered to my satisfaction prior to treatment.

Signed by Patient, Parent or Agent: _____ Date _____
Print Name _____

Nitrous Oxide Consent

I understand that nitrous oxide is an odorless, non-absorbed gas, that when used by inhalation in the dental setting can reduce gag reflexes, reduce anxiety levels and help in comfort during dental procedures and appointments. If I have taken any prescription sedative or drugs, I will let the doctor know, as some sedatives are contraindicated with nitrous oxide use.

Nitrous oxide can make you feel as if you had a couple glasses of wine but you should return to normal alertness quickly following the procedure. Some patients do not like this feeling or feel claustrophobic under the nose piece. The nitrous can be stopped at any time however we encourage you to breathe pure oxygen for 5-10 minutes to reduce the chances of an intense headache or fatigue following the appointment. These are all normal risks of nitrous oxide sedation for dentistry.

I have read the above pre and post-operative information, and agree to the administration of nitrous oxide during treatment _____. (patient/ guardian signature)

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PATIENT CANCELLATION POLICY

Please understand that when we schedule your appointment, we are reserving time for your particular needs. We reserve a room for you and your records and insurance is verified and prepared. We kindly ask that if you must change an appointment, please give us at least 48 business hours' notice. This courtesy makes it possible to give your reserved time to another patient who is in need of it. Please call the office if you need to cancel or reschedule an appointment.

We understand that emergencies happen, and will work with any patient that may need to move an appointment. Thank you for your understanding and in order to provide the best experience for all of our patients, we ask that you arrive at your scheduled appointment time.

☐ **I understand that there is a $40 charge (per appointment) if I cancel without providing a 48 business hours' notice or if I do not show for my appointment. The payment must be made in order to schedule my next appointment.**

Printed Patient Name(s): _____

Signature: _____ Date: _____

Pre-Treatment Deposit Policy

To better accommodate our patients and to ensure our schedule runs efficiently, our policy at Kingwood Dental Specialists is to collect a pre-treatment deposit of 50% (of patient portion) from all patients prior to scheduling any treatment procedures.

The deposit will be applied to any services related to the treatment. The remainder of the balance will be due on the day of treatment. Cancellation of treatment must be done 5 business days prior to the day of treatment otherwise the deposit will be forfeited.

☐ **I understand that I will be forfeiting my deposit if I cancel my treatment appointment within 5 business days of scheduled treatment date.**

Printed Patient Name(s): _____

Signature: _____ Date: _____