THAI PHAM, DMD, PhD

Endodontic Innovations
13127 Kings Lake Drive, Suite 101, Gibsonton, FL 33534

Today's Date: ___________________________

PATIENT INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other   Gender: ☐ Male ☐ Female

First Name: _________________________ Last Name: _________________________ MI: __________

Birth Date: _________________________   Social Security Number: ________________________

Address: ____

City, State: ____ Zip Code: ____________________

Home Phone: ___________________________ Cell Phone: _______________________________

Email: __________________________________ ☐ I would like to receive correspondences via email.

Primary Dental Insurance Company Name: ___________________________

Secondary Dental Insurance Company Name: _________________________

Responsible Party First Name: ______________________ Last Name: _____________________ MI: ___

Relationship to Patient: ____________________________

APPOINTMENT INFORMATION

Reason for visit: ____

Are you experiencing any pain? ☐ YES ☐ NO

If yes, level of pain from 1-10: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

0 1 2 3 4 5 6 7 8 9 10

None Mild Moderate Severe Worst Possible Pain

How often: _________________________ Sensitive to: ☐ Hot ☐ Cold

Does your tooth hurt when you bite down or chew? _________________________

Have you had any restoration on this tooth recently? _________________________

EMERGENCY CONTACT INFORMATION

Contact Name: ___________________________ Phone Number: __________________________

Relationship to Patient: ____________________________

The above information is true to the best of my knowledge.

____   _________________________

Signature of Patient (or Parent)   Date

Endodontic Innovations

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Name: ______________________________ Date: ______________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Question	Answer	
Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Has any physician told you that you need to take antibiotics prior to dental treatment?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	

List of Medications, pills, drugs:

____

____

____

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Question	Answer	
Do you use controlled substances?	◯ Yes ◯ No	If yes
Other?	☐	If yes

Do you have, or have you had, any of the following?

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No	Anemia	◯ Yes ◯ No
Easily Winded	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No	Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No	Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No
Scarlet Fever	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No
Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No
Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No	Bruise Easily	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No
Mitral Valve Prolapse	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Tuberculosis	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No
Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No	Convulsions	◯ Yes ◯ No
Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No				

Have you ever had any serious illness not listed ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:__________

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DISCLOSURE OF HEALTH INFORMATION

I, _________________________, (hereafter "Patient") hereby authorize **Dr. Thai Pham** and or **Endodontic Innovations**, (hereafter collectively referred to as "Practice" to use and disclose the entire medical record concerning Patient with referring dentist or physician and ___________________________________, in

(Name of the person you wish to share your medical records with. Please, add relationship)

accordance with the attached Notice of Privacy Practices (NOPP). I have received a copy of and reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release and hold Practice, its employees and agents harmless from any and all liability including but not limited to negligence) arising out of or occurring under this consent.

This does not authorize any release of records. I understand I must sign a separate release form for the release of records.

____ __________________

By Patient: (print name and sign) Date

Or

____ __________________

By Patient's Representative (Print name and sign) Date

Relationship to Patient: ____

____

NOTE: Do not use this form for disclosure of HIV, Substance Abuse or Psychotherapy Notes

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The Undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Endodontic Innovations this ______ day of _______________, 20___. A copy of this signed, dated Acknowledgement shall be as effective as the original.

____

Please print your name

____

Please sign your name

If you are the legal representative of the patient, please print the patient's name(s)and describe your authority/relationship to the patient:

____

Thank you and if you have any questions about this form or the attached Notice, please contact our Privacy Official, _______________________

Office Use Only

As Privacy Official, I attempted to obtain the patient's (or representative's) written acknowledgement of our Notice of Privacy Practices due to the following reason.

- It was an emergency treatment ____
- The patient refused to sign _____
- Communication Barriers _____
- The Patient was unable to sign because (please describe) ____

____

____

____

____

Signature of Privacy Official

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Vital Information about your Dental Insurance

Our office is happy to help you file your insurance to receive the dental benefits that you and your employer are paying premiums for. Dental benefit plans can vary from company to company with different procedures covered or not covered. **Insurance companies base the amounts that they will pay toward your dental treatment on restricted fee schedules related to premium payments and geographical location. In other words, your insurance plan will pay only what it allows for each service, regardless of what the actual fee might be**. Deductibles and co-payments are typically built into most plans and their required payment is strictly regulated by state law. Both our office and you as the policy beneficiary can be prosecuted if deductibles and co-payments are not collected. Your Employee Benefits Director can usually help you become familiar with your plan and its restriction, and our office will assist you in maximizing your benefits.

Our responsibilities:

1. Complete your insurance claim forms and submit them to your carrier for you after your treatment is completed.
2. Use current American Dental Association coding for correct reporting of procedures.
3. Accept direct payment from your carrier (if we are the provider for your insurance company) and keep track of balances.
4. If necessary, re-file your insurance a second time within a 60 day period.

Your responsibilities:

1. To provide our office with necessary information concerning your insurance coverage to allow corrects filing of claims.
2. To understand that your plan is a contract between you and your employer and the insurance carrier. Our office will do all we can to facilitate claims payment, but we do not have the power to make your plan pay.
3. To pay your account balance on the same day that services are rendered.

We thank you for choosing our office and will do all we can to help you obtain the benefits you deserve. Please sign this form below. We will keep this copy in your chart. If you would like a copy for your own record, please let us know.

I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third payers.

______________________________________ ________________________

Patient or guardian **Date**

We will accept direct assignment of benefit if we are the provider for your insurance company. Please read the below and sign if this applies to you.

I hereby authorize payment directly to the dental office of the insurance benefits otherwise payable to me. I understand that I am ultimately responsible for all costs of dental treatment. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third payers.

______________________________________ ____________________________

Patient or guardian **Date**

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Financial Policy

Thank you for choosing our practice to serve your dental needs. Please take the time to read the following, initial each section, and sign and date the bottom of this form.

_________ Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

________ Insurance balances are ultimately the patient's obligation. We will file with most primary insurances at no cost to you as a courtesy. However, insurance balances which are not paid within 60 days may be billed to you. Please keep your walk-out statements and follow-up with your insurance carrier to ensure proper payment.

__________ Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility.

__________ **A deposit equal to at least one half of the estimated patient portion is required at the time the appointment is made.**

__________ Patients are asked to confirm their appointments at least 48 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to confirm may result in loss of appointment time.

__________ **There will be a fee of $75 for failed appointments or those rescheduled without 48 hour notice.**

___________ Patient balances that go unpaid for 30 days or more may incur one or more of the following charges:

Interest charges of 1.5% per month
18% APR collections fees (up to 25% of the full balance)
Legal fees for collection services

____ ________________________
Signature of Patient, Parent or Guardian Date

____ ________________________
Print Name Witness