Welcome!

Connecticut Endodontics
Rick Morant, DMD, MS

PATIENT INTAKE FORM

Today's Date:_____
Patient Name: _____ SSN: _____ Sex: M F
Address: _____ City: _____ State: _____ Zip: _____
Home #: _____ Cell#: _____ Age: _____ DOB: _____ ☐ Married ☐ Single
General Dentist: _____ **Referred By** (if other than dentist): _____
Emergency Contact name: _____Emg contact phone:_____

GUARANTOR

If the person financially responsible for this account is someone other than the patient, please fill out this section:
Name:_____ Relationship:_____SSN: _____
Address: _____ City: _____ State: _____ Zip: _____
Home #: _____ Cell#: _____ DOB: _____ ☐ Married ☐ Single
Employer: _____ Address: _____ Work #:_____
Driver's License #: _____ Email: _____

INSURANCE

Name of Subscriber:_____DOB:_____ SSN: _____ Sex: M F
Primary Insurance Co: _____Phone #: _____ Payor ID: _____
Claims Mailing Address: PO Box_____City:_____State: _____ Zip: _____
Employer: _____ Subscriber ID:_____ Group #:_____

MEDICAL HISTORY

Reason for today's visit: _____Estimation of your general health?_____
Preferred Pharmacy/location:_____ Pharmacy Phone#:_____
Are you **allergic** to any medications or latex? ☐ No ☐ Yes (list)

_____
Please list ALL medications you are taking at this time:_____
_____

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

☐ No ☐ Yes Heart Disease	☐ No ☐ Yes Glaucoma	☐ No ☐ Yes Stomach Ulcers
☐ No ☐ Yes Heart Attack	☐ No ☐ Yes Diabetes	☐ No ☐ Yes Kidney Problems
☐ No ☐ Yes Heart Murmur	☐ No ☐ Yes Anemia	☐ No ☐ Yes Cancer
☐ No ☐ Yes High Blood Pressure	☐ No ☐ Yes Bleeding Problems	☐ No ☐ Yes Radiation/Chemo
☐ No ☐ Yes Rheumatic Fever	☐ No ☐ Yes Systemic Lupus	☐ No ☐ Yes Psychiatric Care
☐ No ☐ Yes Mitral Valve Prolaps	☐ No ☐ Yes Hepatitis	☐ No ☐ Yes Fainting Tendency
☐ No ☐ Yes Shortness of Breath	☐ No ☐ Yes Thyroid Disease	☐ No ☐ Yes HIV/AIDS
☐ No ☐ Yes Chest Pains	☐ No ☐ Yes Tuberculosis	☐ No ☐ Yes Treatment w/ Steroid
☐ No ☐ Yes Sinus Problems	☐ No ☐ Yes Severe Headaches	☐ No ☐ Yes Organ Transplant
☐ No ☐ Yes Lung Problem/Asthma	☐ No ☐ Yes Seizures	☐ No ☐ Yes Liver Problem/Jaundice
☐ No ☐ Yes Hip/Joint Replacement	**☐ No ☐ Yes Takes Pre-Med**	**☐ No ☐ Yes Latex/Rubber Allergy**

Please list any other medical problems not listed above: _____
_____
☐ No ☐ Yes **I am currently under a physician's care for any medical condition.** (describe)_____
_____Physicians Name:_____ Phone #:_____
☐ No ☐ Yes **I have been hospitalized within the past year.** (reason)_____
☐ No ☐ Yes **I am currently pregnant.** How many weeks?_____
☐ No ☐ Yes **I am currently breast feeding.**
☐ No ☐ Yes **I am currently taking bisphosphonates.**(Osteoporosis medication)
☐ No ☐ Yes **I am currently taking oral birth control pills.** (Antibiotics may decrease the effectiveness.)

ACKNOWLEDGEMENT OF RECEIPT OF THE **HIPPA NOTICE OF PRIVACY** AND **FINANCIAL POLICY** OF CONNECTICUT ENDODONTICS, LLC

☐ *I hereby acknowledge that I have read/requested a copy of the office HIPPA Notice of Privacy Policy.*
☐ *I have been given the opportunity to ask questions regarding this policy and give **Connecticut Endodontics, LLC** permission to send my information to my General Dentist/Specialist, Medical Physician, and/or my Insurance Company if it is requested.*
☐ *I have read/accept **Connecticut Endodontics, LLC Financial Policy** and Understand that I am responsible for any unpaid balance.*

Patient/Guarantor (print name):_____**Signature :** _____ **Date:**_____

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INFORMED CONSENT

This document signed and dated, is my consent for **Connecticut Endodontics, LLC** to perform any dental treatment deemed necessary in an attempt to preserve my tooth with root canal therapy. This document will allow **Dr. Rick Morant** to perform a diagnosis, administer local anesthesia, and, if necessary, perform root canal therapy and any other necessary post-operative care needed.

Root canal treatment is the procedure of cleaning and filling the inside of a tooth that has become diseased or infected. Your treatment may take more than one visit. You may experience some soreness and discomfort in and around the tooth being treated. Root canal treatment may allow the tooth to remain in the mouth for many years, if not a lifetime.

Although root canal therapy has a high degree of sucess, a perfect result cannot be guaranteed. I have been informed that there are certain uncontrollable risks that can arise and can lead to further treatment being necessary. Some of these potential risks include, but are not limited to, the following:

- Fracture of existing tooth structure, fillings, crowns, and bridges.
- Short term muscle and jaw pain.
- Temporary or permanent numbness of lip or face from anesthesia or surgery.
- Extremely calcified, curved or previously treated canals can increase the difficulty of treatment causing canal blockage, ledging, root perforation, or broken instruments.
- Post-operative pain, swelling and/or infection.
- Overfills or underfills of gutta percha and/or sealer.
- Multi-focal pain may require treatment of more than a single tooth to alleviate pain.

The other treatments, which could be necessary, include, but are not limited to, the following: retreatment, surgery, root removal, or even extraction.

I also understand that some teeth may have existing fractures, and this can lead to eventual extraction of the tooth although the fractures are not detectable at the time of treament. Most fractures that are in the clinical crown of the tooth are easily restorable with root canal therapy and a **full coverage crown** restoration. Fractures that extend to the root portion of the tooth may or may not be detectable at time of treatment and can eventually lead to continued chewing pain and eventual extraction.

Once your root canal therapy has been completed, **it is your reponsibility to see your dentist in a timely manner (within 4 weeks after treatment) and have the tooth permanently restored.** Failure to have the tooth restored in a timely manner could lead to recontamination of the root canal filling material and subsequent infection with the possible need for retreatment at the patient's expense.

_____	_____	_____
Print Name	**Signature**	***Today's Date***

_____

Patient's Name (if a guardian or guarantor is signing for a patient)

Connecticut Endodontics, LLC
1358 Boston Post Rd., Old Saybrook, CT
860-388-3522

Connecticut Endodontics

FINANCIAL POLICY

- **We will inform you of the fee** for your upcoming treatment, diagnostic evaluation, or scan
- **Payment is due at the time of your visit.** Acceptable forms of payment are: cash, checks, credit, debit, and CareCredit.
- **This office does not offer extended billing or monthly billing plans*.** Balances over 60 days are subject to an 18% APR finance charge.

  *For patients who qualify, 12 month deferred interest payment plans are available through Synchrony Bank. Ask a staff member for details or visit www.carecredit.com for pre-approval.
- Open account balances over 90 days may be sent to an outside collection agency, and are subject credit bureau reporting and an additional $25 collection fee.

FOR THOSE PATIENTS WITH INSURANCE:

- We are pleased to assist you by filing your insurance claim for you. **We will file insurance claims for any Dental Insurance plan,** but we may not be contractually obligated to adjust our fee to your insurance company's arbitrarily determined fee allowance.
- **You will be responsible for the difference between what the insurance pays and our fee for service.**
- Dr. Morant is a contracted provider for **Delta Dental Premier Network.**
- **It is your responsibility to provide accurate, complete, and up-to-date insurance subscriber information.**
- We will do our best to estimate and inform you of your "out-of-pocket" cost using the information you have provided. **This is only an estimate,** made with the information provided, with the tools we have access to, on this day, and is not a guarantee of payment by any insurance company. Estimates are subject to change. If you require a more specific determination of your insurance benefits **we recommend filing a pre-estimate with your insurance company.** This can take anywhere from a few days to several weeks for us to receive.
- **You are responsible for paying the out-of-pocket estimate at the time of your visit.**
- If your insurance company has not paid your claims within 45 days, then you will be billed for the full amount of the open balance. If you feel you have been billed due to an error in processing your claim, please contact us immediately and we will make an attempt to resolve errors in claims filed on your behalf. Regardless of insurance claim status, if we are unable to resolve errors after 45 days, the unpaid balance becomes your responsibility and is subject to applicable interest charges. Please be aware that our ability to file, amend, or appeal claims expires 12 months after treatment.

I _____(print name) have been informed of the fees and I accept responsibility for payment at the time of my visit and any remaining amount my insurance company does not pay. I have read and understood the financial policy above.

_____	_____	_____
Print Name	Signature	Today's Date

_____
Patient's Name (if a guardian or guarantor is signing for a patient)

CONNECTICUT ENDODONTICS, LLC
ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this notice

A copy of the policy can be found on our website www.ctendo.com and is displayed in our office. A free printed copy is available by request.

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____

Print

_____

Sign

_____

Date