HEALTH QUESTIONNAIRE

Today's Date: _____/_____/_____Name _____ MI_____ Last Name_____ □ Male □ Female

Date of Birth _____ / _____ / _____ Name of Parent or Legal Guardian (if minor) _____

Address_____ City _____State ___ Zip _____Email address _____

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone (_____) _____

Place of Employment _____ SSN _____- _____ -_____

Primary Dental Insurance Carrier_____ Subscriber Name_____
Subscriber Policy Holder Date of Birth_____/_____/_____SSN or ID#_____
Subscriber Place of Employment _____Group #_____
Subscriber Address if different from above _____

Secondary Dental Insurance Carrier _____Subscriber Name _____
Subscriber Date of Birth _____/_____/_____ SSN of ID#_____
Secondary Subscriber Place of Employment _____Group #_____
Subscriber Address if different from above _____

Emergency Contact _____Phone (_____) _____ Cell Phone (_____) _____
Whom may we thank for referring you? _____

Do any of the below conditions apply to you? (Please check yes or no)

	YES	NO		YES	NO
PREMEDICATION for Dental Visits			Anemia		
High Blood Pressure /Hypertension			Bleeding Disorder / Hemophilia		
Low Blood Pressure			Kidney Disease/ Renal Dialysis		
Heart Murmur			Organ Transplant		
Rheumatic Fever			Cancer (Type _____)		
Mitral Valve Prolapse (MVP)			Chemotherapy/Radiation Therapy		
Angina Pectoris / Chest Pain			Epilepsy / Seizure		
Heart Attack			Stomach Ulcer		
Prosthetic (artificial) Heart Valve			Colitis / Intestinal Problems		
Irregular / rapid heart beat			Osteoarthritis		
Pacemaker / Implanted defibrillator			Rheumatoid Arthritis / Lupus		
Heart Disease/Heart Surgery/ Bypass			Artificial Joints / Screws		
Stroke			Sexually Transmitted Disease (STD)		
Emphysema			AIDS / HIV		
Asthma			Tuberculosis (TB)		
Diabetes (Type _____)			Psychiatric Treatment		
Thyroid Disease / Goiter			Alcohol / Substance Abuse		
Jaundice / Liver Disease			Allergy to Latex		
Hepatitis (Type _____)			Pregnant / Nursing		
Blood Transfusion			Other (specify) _____		

Medications/Reason_____

_____

Allergies_____

_____

Hospitalizations/Surgeries_____

_____

Any Other Additional Medical Concerns? _____

_____

Health Care Provider Information

Family Physician
Complete Name:_____ Telephone Number:_____

General Dentist
Complete Name:_____ Telephone Number:_____

Pharmacy
Complete Name:_____ Telephone Number:_____

PATIENT RECORD OF DISCLOSURES

I wish to be contacted in the following manner:

Home Telephone: _____ Cell Telephone: _____ Work Telephone: _____

___ Ok to leave message with detailed information
___ Leave a voice message with a call back number only
___ I prefer you only speak with me

Written Communication: _____ OK to mail to my home address _____ OK to mail to my work address:
_____.

Persons authorized to speak with us?

Name	Relationship
_____	_____
_____	_____
_____	_____

I certify that all the proceeding answers contained in this health history are complete and true. I understand that responding inaccurate could be dangerous to my health and cause adverse reactions during dental treatment. I understand that I am responsible for any errors or omissions that I may have made in completion of this form. It is my responsibility to inform the clinician of any health changes prior to services being rendered. I hereby authorize Snyder Endodontics, PLLC to release the necessary information to secure the payment of third party benefits. I authorize the use of this signature on all insurance submissions. I agree to be responsible for payment of all services rendered if not covered by the dental insurance.

If I am not able to keep an appointment I am required to inform Snyder Endodontics, PLLC at least 24 hours in advance. If 24 hour notice is not given, I may be charged a $50 cancellation fee.

_____ _____

Patient or Legal Guardian (Signature/Print Name) **Date**

INFORMED CONSENT FOR ROOT CANAL TREATMENT OR RETREATMENT

We would like our patients to be informed about the various procedures involved in Endodontic therapy and have their consent before starting treatment. Endodontic (Root Canal) therapy is performed in order to save a Tooth which otherwise might need to be extracted. This is accomplished by conservative Root Canal treatment or, when needed, Endodontic Surgery. The following discusses the possible risks that can occur from or during Endodontic treatment, as well as risks involved with other treatment choices.

RISKS: Included, but not limited to, are complications from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics and injections, swelling, sensitivity, bleeding, pain, infection, numbness and a tingling sensation in the lip, tongue, chin, gums, cheeks and teeth. These complications are transitory, but on infrequent occasions can be permanent. Other risks include reaction to injections, changes to occlusion (biting), jaw muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth, referred pain to ear, neck and head, nausea, vomiting, allergic reactions, delayed healing, sinus perforations and treatment failure.

RISKS MORE SPECIFIC TO ENDODONTIC TREATMENT: The risks include the possibility of instruments broken within the root canals, over or under fill, perforations of the crown or root of the tooth, damage to bridges, existing filling, crowns or porcelain veneers, loss of tooth structure in gaining access to canals, and cracked teeth. During treatment, complications may be discovered which make treatment impossible or may require dental surgery. These complications may include blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal (gum) disease or splits or fractures of tooth/roots.

MEDICATIONS: If needed, prescribed medications and drugs may cause drowsiness and lack of awareness and coordination, which can be influenced by the use of alcohol, tranquilizers, sedatives and other drugs. It is not advisable to operate any vehicle or hazardous device until recovered from the effects.

CONSENT: I, the undersigned, am the patient (parent or guardian of minor patient) and I consent to the performing of procedures deemed necessary or advisable in the opinion of the Doctor. I understand the importance of giving a truthful health history to assist the Doctor in providing the best care possible. I also understand that upon completion of the Root Canal Therapy in this office, I shall return to my General Dentist for permanent restoration of the tooth involved. The fee for the final restoration is a separate fee charged by my General Dentist and is not included in the Root Canal fee. Failure to follow-up with the final restoration in a timely manner may result in failure of the Root Canal.

INSURANCE: I understand that my Dental Insurance is a contract between the Insurance Carrier and me and not between the Insurance Carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all Insurance Benefits to the Doctor. Any payments received by the Doctor from my Insurance Coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred.

COLLECTIONS: Please be advised that if collections proceedings ever have to be entered into regarding unpaid balances, any and all legal and court related costs in connection with the collection of a past-due account becomes the responsibility of the patient and will substantially increase the amount owed.

I understand that Root Canal Therapy is a biological procedure in an attempt to save a tooth that may otherwise require extraction. Although Root Canal Therapy has a high degree of success, it cannot be guaranteed. Successful completion of the Root Canal treatment does not prevent future decay or fracture. Occasionally, a tooth that has had Root Canal Therapy may require treatment, surgery or even extraction.

_____ _____

Patient (Guardian) Signature/Print Name **Date**

_____ _____

Witness Signature/Print Name **Date**

Snyder Endodontics, PLLC Financial Policy

Thank you for choosing Snyder Endodontics, PLLC as your dental specialty care provider. The following information describes our Financial Policy. Our primary goal is that you receive the optimal treatments needed to restore and maintain your dental health. Therefore if you have any questions about our financial policy, please do not hesitate to ask.

Payments: Unless other arrangements are approved by us in writing, and signed, the balance on your account is due and payable when services are rendered.

Dental Insurance: **Payment in full is required at the time of service.** Dental insurance is a contract between you, your employer and your insurance company, and never a guarantee of any payments. You are responsible for any balance not paid by your insurance company. *If you have an insurance policy that we are participating with, and OR the assignment of benefits will be sent to us directly from the insurance company, we ask that you pay your estimated portion at the time of your appointment.* For all other insurances, full payment is due at the time of the visit and as a courtesy to you, we will submit a claim on behalf to your insurance company and they *will provide reimbursement directly to you.*

IMPORTANT: Although we may estimate what your insurance may pay, it is the insurance company that makes the final determination of your eligibility and payment received. Payment from your insurance is never a guarantee. You are fully responsible for any balance not paid by your insurance company. We recommend that you understand your insurance policy; its limitations and benefits.

Please **initial** that you have read and understand the above statement _____ **Initials.**

Missed Appointment Fee: We make every effort to schedule appointments at your convenience and also confirm your appointment in advance. We do require at least 24 hour notice (one business day) if you are unable to keep your appointment. If you fail to make your appointment you will be charged a $50.00 cancellation fee. This fee must be paid before another appointment is scheduled.

Please **initial** that you have read and understand the above statement _____ **Initials.**

Payment Options:

- You may choose to pay by cash, check, or credit card.
- We accept Visa, MasterCard, American Express, and Discover.
- We also participate with Care Credit **(carecredit.com)**. They offer several financing options, some of which are interest free.

Past Due Accounts: Any accounts over 90 days are automatically referred to a collection agency or reported as delinquent to the credit bureau. You agree to pay all costs which are incurred as a result of these actions. Accounts over 30 days will incur an 18% monthly finance charge unless other arrangements have been made.

Returned Checks: There is a $30.00 fee for any checks returned from the bank.

By signing this agreement, you understand and agree to all the terms and conditions contained herein and realize this agreement will be in full force. All questions were answered to your satisfaction.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to call us so that we can assist you in the management of your account.

Again, thank you for choosing Snyder Endodontics, PLLC for your dental care. We appreciate your confidence in us and the opportunity to serve you.

Name of person Responsible for Account: _____

Relationship: self _____parent _____

Signature: _____ **Print Name:** _____ **Date:** ____/____/____

Staff Signature: _____ **Print Name:** _____ **Date** ____/____/____

Internal Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Your protected medical information (i.e., individually identifiable information, such as Names, dates, phone/fax numbers, email addresses and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other health care providers (i.e., general dentist, oral surgeon, etc.) in connection with our rendering dental treatment to you (i.e. to determine the results of treatment, biopsy, surgery, etc.);
- To third party payers or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine Benefits, dates of payment, etc.);
- To certifying, licensing and accrediting bodies (i.e. State Dental Boards, etc.) in connection with obtaining certification, licensure or accreditation;
- Internally, to all staff members who have any role in your treatment; and/or
- To other patients and third parties who may overhear conversations about your treatment, scheduling, etc.
- To your family and close friends involved in your treatment, and/or,
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any
Questions about the information in this Notice please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

PATIENT ACKNOWLEDGMENT

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

_____	_____	_____
Patient Signature or Legal Guardian	**Print Name**	**Date**

For Office Use Only

Snyder Endodontics, PLLC attempted to obtain written acknowledgement of our Notice of Internal Privacy, but acknowledgement could not be obtained.

- ☐ Individual refused to sign. Specify_____
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An Emergency situation prevented us from obtaining acknowledgement
- ☐ Other (specify) _____

_____