Welcome to Seven Hills Endodontics

(**Please print)**

Patient Information

Patient Name: ____ Date:______________
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child

Patient Social Security #: _________________________ Patient Birth Date: _______________

Phone (Home): _______________ (Work): ______________ Ext: _____Cell: ______________

Email: _____________________________ Preferred contact method: ☐ Phone ☐ Mail ☐Email

Address: ____
Street Apartment #

____
City State Zip Code

Health Information

When was your last dental visit: ___________Reason for that visit: ________________________

Have you ever had any of the following? Please check those that apply:

☐ AIDS/HIV
Allergies:
- ☐ Latex
- ☐ Codeine
- ☐ Penicillin
- ☐ Sulfa
- ☐ Seasonal
- ☐ Environmental
- ☐ Food
- Other:
 ____
 ____

☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis ☐A ☐B ☐C
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Pregnancy
Due date:_________
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
Other:
____
____
____
____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
 If yes, please explain:____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
 If yes, please explain:____
- Are you now under the care of a physician? ☐ Yes ☐ No
 If yes, please explain:____
- Name of Physician: ____________________________________ Phone:_______________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
 If yes, please explain:____
- Have you ever taken Bisphosphonates? ☐ Yes ☐ No
 Examples:Etidronate (Didronel), Tiludronate (Skelid), Alendronate (Fosamax), Risedronate (Actonel), Ibandronate (Boniva), Pamidronate (Aredia), Zoledronate (Zometa) (Reclast).

Are you currently taking any medication? If so, please list name and reason:

____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date:_______________
Signature of patient, parent or guardian

Emergency Contact Information

Name: ____

Relation: ☐ Spouse ☐ Parent ☐ Friend ☐ Neighbor ☐ Other____________________

Phone (Home): ______________ (Work): ______________ Ext:______ Alt. Phone: ________________

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Insurance Company ☐ School ☐ Work ☐ Other____________

Name of person or office referring you to our practice:______________________________

Spouse or Responsible Party Information

(If you are the insured you do NOT need to fill out this section)

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): ______________ (Work): ______________ Ext:______ Best time to call: ______________

Address: ____

Street Apartment #

____

City State Zip Code

Consent for Services & Financial Policy

(Please read carefully and sign)

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.
All emergency dental services, or any dental services performed without previous financial arrangements must be paid for in cash at the time of service.

· **A fee of $100 is charged for patients who miss, cancel or reschedule an appointment more than twice without a 24-hour notice.**

· **I understand that I will be given an ESTIMATE of my insurance benefits and that this is not a guarantee of claim payment.**

I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the examination. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I understand my estimated co-pay and/or co-insurance payment is due at the time services are rendered in the form of cash, credit or debit card, care credit or by a monthly payment plan through our office. Payment plans require a credit/debit card.

We DO NOT accept checks as payment at the time of service.
Co-insurance is collected in full at the time services are rendered.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. Accounts with unpaid balances over 180 days past the date of service are considered delinquent and are subject to a 39% collections penalty and collection procedures.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee to call me at home, work or at any other phone line provided to discuss matters related to this form.

I have read the above conditions of treatment and payment to ***Seven Hills Endodontics*** and agree to the content.

______________________________________ Date: ____________ Relationship to Patient: ________________

Signature of guarantor of payment/responsible party

SECTION A: PATIENT GIVING CONSENT

Name: ________________________________ Date of Birth: ___________

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By either printing and signing this form, or submitting this form electronically, you consent to ***Seven Hills Endodontics*** use and disclosure of your protected health information to carry out treatment, payment activities, and health care 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 health care 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. 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 on this website or by contacting our office during our regular business hours:

Telephone: 702-384-0053 Fax: 702-269-6063
Address: 9550 S. Eastern Ave. #248 Las Vegas, NV 89123
Email: sevenhillsendodontics@gmail.com

Right to Revoke: You have the right to revoke this Consent at any time by sending written notice of your revocation to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we have taken in reliance on this Consent before we received your revocation. Also, we may decline to treat you or to continue treating you, if you revoke this Consent.

I, ____ (**printed**) 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 to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

SIGNATURE

Patient Signature____ Date: _________________

(Parent signature if patient is under 18)

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

Seven Hills Endodontics

TELL US ABOUT YOUR DENTAL SYMPTOMS
Check only those that apply

Name: ______________________________________ **Date:** ________________

Are you experiencing any pain at this time? ☐ Yes ☐ No

If yes, where is the pain located in your mouth? ______________________________________

When did you first notice the symptoms? ______________________________________

Did symptoms occur suddenly or gradually? ______________________________________

Please check the frequency and quality of the discomfort and the number that most closely reflects the intensity of your pain

LEVEL OF INTENSITY (On a scale of 1 to 10) 1=Mild 10+ Severe	FREQUENCY	QUALITY
1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐	☐ Constant	☐ Sharp
	☐ Intermittent	☐ Dull
	☐ Momentary	☐ Throbbing
	☐ Occasional	

Is there anything you can do to relieve the pain? ……………………………………………………☐ Yes ☐ No

If so, what? ______________________________________

When eating or drinking, is your tooth sensitive to**:** ☐ **Heat** ☐ **Cold** ☐ **Sweets** ☐ **N/A**

Does your tooth hurt when you bite down or chew? ☐ Yes ☐ No

Does it hurt if you press the gum tissue around this tooth? ☐ Yes ☐ No

Does a change in posture (lying down or bending over) cause your tooth to hurt? ☐ Yes ☐ No

Do you grind or clench your teeth? ☐ Yes ☐ No
If so, do you wear a night guard? ☐ Yes ☐ No

Has a restoration (filling or crown) been placed on this tooth **recently**? ☐ Yes ☐ No

Prior to this appointment, has root canal therapy been started on this tooth? ☐ Yes ☐ No

Any past trauma or injury to this tooth? ☐ Yes ☐ No

Please describe trauma ______________________________________

____

Is there anything else we should know about your teeth, gums or sinuses that would assist us in our diagnosis?

____

____