ALEXANDRIA ENDODONTICS

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES				
PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)		ADDRESS		
CITY, STATE		ZIP	HOME PHONE	CELL PHONE
PATIENT DATE OF BIRTH	PATIENT SSN	SEX ❑ Male ❑ Female	MARITAL STATUS ❑ Single ❑ Married ❑ Other_____	
PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)		EMPLOYER PHONE	
INSURED/RESPONSIBLE PARTY INFORMATION		RELATION TO PATIENT: ❑spouse ❑parent ❑guardian		
NAME (FIRST -- LAST -- MIDDLE INITIAL)	ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER
INSURANCE INFORMATION				
PRIMARY DENTAL INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)		PHONE	
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE	
SECONDARY DENTAL INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)		PHONE	
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE	
PRIMARY DENTIST	REFFERING DENTIST			
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER		
PRIMARY PHYSICIAN	PHONE			

	Yes	No	Don't Know
1. Do you have unhealed injuries or inflamed areas, growths or sore spots in or around your mouth? If yes, please explain.			
2. Are you under the care of a physician for a current problem? If yes, explain.			
3. Have you been hospitalized within the past 5 years? Please specify.			
4. Are you taking any medication or drugs? Please list them on page provided in this packet.			
5. Have you received therapy for alcoholism or drug addiction during the past 5 years?			
6. Have you ever had any ALLERGIC or ADVERSE REACTIONS to anesthetics/antibiotics/ medications? Please list on the page provided.			
7.Is there any condition concerning your health that the doctor should be told?			
8. Do you wish to speak to the doctor privately about anything?			
9. Have you had abnormal bleeding with previous extractions, surgery, or trauma?			
10. Have you ever required a blood transfusion?			
11. Have you ever had surgery and/or radiation for a tumor, growth, or other condition?			
12. Have you ever tested positively for HIV infection or AIDS? If so, state date diagnosed and treating doctor.			
13. Are you required to take antibiotics prior to dental treatment for reasons other than current tooth infection?			
14. Women only: are you pregnant, nursing or on birth control pills?			

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

☐	High blood pressure	☐	Sinus trouble
☐	Heart murmur or prolapsed valve	☐	Thyroid problems
☐	Joint prosthesis (hip, knee, etc.)	☐	Diabetes
☐	Rheumatic fever or rheumatic heart disease	☐	Stomach ulcers, colitis
☐	Congenital heart disease	☐	Hepatitis, jaundice, liver disease
☐	Cardiovascular disease: heart attack, stroke or bypass	☐	Psychiatric treatment
☐	Prosthetic heart valve	☐	Fainting spells or seizures
☐	Blood disorder (e.g. anemia)	☐	Epilepsy
☐	Venereal disease	☐	Cancer
☐	Asthma	☐	Temporomandibular joint disorder(TMJ)
☐	Allergy to latex	☐	Low blood sugar
☐	Low blood pressure	☐	Dialysis
☐	Chest pain, angina	☐	Irregular heart beat
☐	Swollen ankles, arthritis or joint disease	☐	Contagious diseases
☐	Cardiac pacemaker	☐	Bronchitis, chronic cough
☐	Heart surgery	☐	Hay fever or sinus problems
☐	Delay in healing	☐	Problems with the immune system
☐	Tuberculosis	☐	Difficult breathing or other lung trouble
☐	Emphysema	☐	Chronic fatigue or night sweats
☐	X-Ray treatment or chemotherapy	☐	History of drug abuse
☐	On a diet	☐	Wear contact lenses
☐	History of alcohol abuse	☐	Bruise easily
☐	Eye disease or glaucoma	☐	Gallbladder trouble
☐	Infectious mononucleosis	☐	None of the above

	Yes	No	Don't Know
16. Are you taking any herbal medicine (i.e., St. John's Wort)?			
17. Have you ever taken the "fen-phen" diet?			
18. Do you have any disease, condition or problem not listed above? Specify.			

Please continue:
Women only:

Possibility of pregnancy:	YES / NO	Nursing:	YES / NO
Estimated delivery date:		Taking birth control pills:	YES / NO

NOTE: **Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/ gynecologist for assistance regarding additional methods of control.**

Injury:

This visit is related to an accident	YES / NO	Work related:	YES / NO
Date of injury:			
Insurance company handling the claim:			
Claim Number:			

_____ _____

Patient Signature (Parent signature if patient is under 18 years of age). Date

Please list all medications you are currently taking below:

Please list any allergies:

Alexandria Endodontics
Daniel Lester, D.D.S.
Victor Caronna, D.D.S.
213 Ansley Blvd
Alexandria, LA 71303

CONSENT FOR ENDODONTIC THERAPY

Please review the following consent form. You will be required to sign this form prior to the initiation of treatment. Your signature does not commit you to any treatment.

Occasionally, medication will be prescribed by Dr. Lester and/or Dr. Victor Caronna. Medications prescribed for discomfort and/or sedation may cause drowsiness, which can be increased by the use of alcohol or other drugs. We advise that you do not operate a motor vehicle or any hazardous device while taking such medications. In addition, certain medications may cause allergic reactions, such as hives or intestinal discomfort. If any of these problems occur, call Dr. Lester and/or Dr. Victor Caronna immediately. It is the patient's responsibility to report any changes in his/her medical history to Dr. Lester and/or Dr. Victor Caronna.

I understand the root canal therapy is a procedure that retains a tooth, which may otherwise require extraction. As a specialty practice, this office performs only endodontic therapy and associated surgery. Although root canal therapy has a very high degree of success, results cannot be guaranteed. Occasionally, a tooth, which has had root canal therapy, may require retreatment, surgery, or even extraction. Following treatment, the tooth may be brittle and subject to fracture. A restoration (filling), crown and/or post and core will be necessary to restore the tooth, and your general dentist will perform these procedures. During endodontic treatment, there is the possibility of instrument separation within the root canals, perforations (extra openings), damage to bridges, existing fillings, crowns or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals, and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when the tooth may not be amenable to endodontic treatment at all. Other treatment choices include no treatment, a waiting period for more definitive symptoms to develop, or tooth extraction. Risks involved in those choices might include, but are not limited to, pain, infection, swelling, loss of teeth, and infection to other areas.

All of my questions have been answered by Dr. Daniel Lester and/or Dr. Victor Caronna, and I fully understand the above statements in this consent form.

Furthermore, I give Alexandria Endodontics my permission to voice record, tape digitally, videotape and/or take 35mm and/or digital photos of my procedure for purposes of completing my medical record and/or for patient education.

Note: All medical records will be kept strictly confidential.

Patient (Print Name) _____

Patient (Signature) _____

Date _____

(If patient is under the age of 18, the signature of a parent or guardian is required.)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
and
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ FOLLOWING STATEMENTS 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, insurance claims, and healthcare operations.

Notice of Privacy Practices: Our Notice provides a description of our treatment, payments 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 accompanies this Consent. 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:

Alexandria Endodontics
1431 Peterman Drive
Alexandria, LA 71301
Phone: 318-443-5013 FAX: 318-443-5014

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 you or to continue treating you if you revoke this Consent.

Signature Below Acknowledges Receipt of Notice of Privacy Practices and Consent for the Use and Disclosure of Your Health Information:

I, (Print Name) _____, have had full opportunity to read and consider this Consent form and the Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent to office use and disclosure of my protected health information to carry out treatment, payment activities, insurance claims and health care operations.

Signature: _____ Date: _____

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

Representative's Name: _____ *Relationship to Patient* _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledge could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Specify) _____

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Alexandria Endodontics Payment Policy

This is a referral practice, and a mutual respect to obligations is essential to permit our business to be conducted on an efficient and friendly basis. Therefore, to avoid misunderstandings concerning payments of accounts, please note that endodontic treatment is **usually** completed in one visit and must be paid in full. **You must provide our office staff with the proper information, Dental Insurance Card, Social Security No., and Date of Birth of the person you are filing dental insurance under must be paid in full the day of the office visit.**

Any discrepancy between the Insurance Company's allowance and your total indebtedness remains your responsibility. **Any insurance claim that has not been paid within 60 days of treatment will be billed back to you.**

I hereby assign, transfer, and set over to Alexandria Endodontics, LLC., all rights, title, and interests to my dental reimbursement benefits under my insurance policy, I authorize the release of any dental information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand I am financially responsible for all charges for my dependents, or myself whether or not they are covered by insurance. I the undersigned agree to pay and understand that a finance charge of 18% per month will be added to all account balances that become over 60 days past due. I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency, (25%), attorney fees and/or court costs, if such be necessary. NSF checks are subject to $25.00 service charge.

Telephone Consumer Protection Act (TCPA)

You agree, in order for us to service your account or to collect monies you may owe, Alexandria Endodontics, LLC., and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that, Alexandria Endodontics, LLC., it's employees and/or agents may contact me/us as described above.

Responsible Party Signature: _____ Date: _____