Pensacola Endodontics LLC

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Pensacola, FL 32503
Phone: 850.696.2401 • Fax: 850.332.6561

Thank you for choosing our office for your endodontic treatment. To help save you time, we have enclosed paper work that includes a medical history sheet, a payment policy, and a treatment consent form. Please take time to complete the paper work prior to your appointment. Also, please feel free to contact our office if you have any questions. We also understand that dental treatment can be a cause of stress and anxiety for some people. If you would like to be prescribed a mild sedative prior to your treatment, please let our office know so that we can schedule a consultation in advance.

We look forward to meeting you and will do our best to meet your treatment needs.

Thank You,
Pensacola Endodontics

PENSACOLA ENDODONTICS LLC

Patient's Name: ______________________ Date of Birth: __________

☐ Male ☐ Female If minor; legal guardian's name: ______________________

Home Address: ______________________ City: __________ State: ____ Zip: ______

Home Phone: __________ Business Phone: __________ Email: __________

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Social Security Number: __________ Place of Employment: __________

If Insured, Dental Insurance Co. ______________________

Policy No. __________ Policy Holder's Place of Employment: __________

Policy Holder's Date of Birth: __________ Policy Holder's Social Security No. __________

Have you ever had root canal treatment before? ☐ Yes ☐ No

Pharmacy: ______________________

Medical History

Please answer all questions carefully. This information is confidential.

Have you ever had: (Check if yes)

- ☐ Heart disease or Heart attack
- ☐ High blood pressure
- ☐ Chest pains (Angina)
- ☐ Mitral valve prolapse
- ☐ Prosthetic heart valve
- ☐ Heart murmur
- ☐ Rheumatic fever
- ☐ Congenital heart defect
- ☐ Anemia
- ☐ Pacemaker
- ☐ Bleeding problems
- ☐ Swelling of hands or feet
- ☐ Artificial joint (hip, knee)
- ☐ Blood transfusion When: __________
- ☐ Tuberculosis (TB)
- ☐ Emphysema
- ☐ Difficulty breathing
- ☐ Asthma
- ☐ Sinus congestion
- ☐ Shortness of breath
- ☐ Other breathing problems: __________
- ☐ Kidney infection
- ☐ Venereal disease
- ☐ Herpes
- ☐ Cold sores or fever blisters
- ☐ Frequent sores or ulcers in mouth
- ☐ Bleeding gums
- ☐ Pain in jaw joint
- ☐ Do you have AIDS or have been exposed to the HIV virus?
- ☐ Epilepsy
- ☐ Dizzy or fainting spells
- ☐ Seizures
- ☐ Psychiatric treatment
- ☐ Tranquilizing medications
- ☐ Hepatitis
- ☐ Yellow Jaundice
- ☐ Liver Disease
- ☐ Diabetes
- ☐ Ulcers or stomach ulcers
- ☐ Thyroid disease
- ☐ Cancer or tumor

Medical History (Cont.)

Are you pregnant? ☐ Yes ☐ No If yes, how many months? ______

Do you take birth control pills? ☐ Yes ☐ No

Do you take anticoagulants? ☐ Yes ☐ No

Are you currently under the care of a doctor? ☐ Yes ☐ No Reason? ______

Name of your Physician: ______

Are you currently taking any prescription medication? ☐ Yes ☐ No

Please list them: ______

Are you allergic to: (Check if yes)

☐ Latex
☐ Aspirin
☐ Codeine
☐ Penicillin
☐ Other Antibiotics
☐ Novocaine
☐ Other Anesthetics: ______
☐ Other Medications: ______

Have you ever had a reaction to an injection or medicine given to you by a dentist? ☐ Yes ☐ No

If yes, please explain: ______

Do you have any disease or condition not mentioned above? ☐ Yes ☐ No

If yes, please list: ______

To the best of my knowledge the above information is accurate and true.

If the patient is a minor, I, as the parent guardian give my permission for any needed dental treatment.

Patient Signature: ______ Date: ______

Doctor Signature: ______ Date: ______

PENSACOLA ENDODONTICS, LLC

FINANCIAL POLICY

Patient Name: ______________________

DOB: ________________

We strive to deliver the finest care at a reasonable fee to our patients; therefore payment of your portion of the fee is due at the time services are rendered.

We recommend and provide the treatment to you that we believe to be in your best interest. Although we may or may not participate with your dental insurance carrier, services will be covered or not covered based on your benefit guidelines. Verification of insurance benefits is NOT a guarantee of insurance payment. If you have dental insurance, your insurance carrier makes the final determination of all coverages. Their decisions may determine that certain procedures are ineligible for reimbursement for various reasons such as plan guidelines, limitations, or exclusions. Your insurance policy is a contract between you and your insurance carrier; our office is not a party to that contract.

It is important to be aware of the following:

During endodontic procedures, it is possible that the tooth may be found inoperable, unrestorable, or fractured. If your tooth is determined to be unfixable , "Incomplete Endo" fee will be applied.

Occasionally, blockages are encountered during treatment that may incurr additional fees.

Please be advised that if for whatever reason your insurance company may deny your claim, you are responsible for all charges from the date services are rendered.

For your convenience we accept Cash, Check, Visa, MasterCard, American Express, Discover and Carecredit.

Signature: ______________________________
If under 18, signature of parent or guardian

Date: ____________________

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Sidney C Rosenthal DMD

Endodontic Information and Consent Form

We would like our patients to be informed about various procedures and understand the risk involved in endodontic therapy and have their consent before starting treatment. Endodontic therapy is performed in order to save a diseased tooth which left untreated will otherwise need to be removed. This is accomplished through conservative root canal therapy and dental surgery when needed. The following discusses possible risk that may occur from endodontic treatment, and other treatment choices.

Risk

The risk include the possibility of broken instruments within the root canals; perforations (extra openings) of the crown or root of the tooth; damage to bridges, crowns, or veneers; loss of tooth structure in gaining access to canals; and fracturing of teeth. Even though these risk rarely occur, they can make the tooth nonrestorable.

Medications

Following endodontic procedures slight to moderate pain may occur with severe pain occurring rarely. Medications that are sometimes prescribed for pain may cause drowsiness and loss of coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives,• or other medications). It is not advisable to operate any vehicle or hazardous device until recovered from their effect. Antibiotics, if prescribed, may temporarily lessen the effectiveness of birth control pills.

Other Treatment Choices

These include no treatment (waiting for more definite development of symptoms) or tooth extractions. Risk involved in these choices might include pain, infection, swelling, loss of teeth and infection in other areas.

Further Treatment

During treatment, complications maybe discovered which may make success through conventional treatment alone impossible, and require further treatment through dental surgery. These complications may include; blocked canals due to fillings or prior endodontic therapy, natural calcifications of the canals, broken instruments, curved roots, periodontal disease (gum disease) or fractures of the teeth.

Consent

I, the undersigned, being patient (parent or guardian of minor patient), consent to the performing of procedures decided upon necessary or advisable in the opinion of the doctor. I understand that although root canal therapy has a very high degree of success, it cannot be guaranteed and may require further treatment. Occasionally teeth that have had root canal therapy, may require surgery, re-treatment, or even extraction. I also understand that upon completion of root canal therapy in this office, I am responsible for the permanent restoration of the tooth involved.

Patient Signature: ______________________________ Date: ______________

The Privacy Of Your Health Information Is Important To Us
We support your right to the privacy of your health information. We are required by applicable federal and state law to maintain the privacy of your health information and to provide you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We reserve the right to make changes in our privacy practices and the terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes.

Uses And Disclosures Of Health Information
This notice allows us to use and disclose health information about you or your minor child if you are a parent or guardian, as necessary for treatment, payment, and healthcare operations. We will limit the release of information necessary to assist in the specific need. Examples include but are not limited to: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Persons Involved In Care: In the event of your incapacity or in emergency circumstances, we will disclose health information based on your signed authorization in your medical records, obtained at your initial visit. We will also use your signed Authorization for Release of Protected Health Information form in allowing a person to pick up prescriptions, medical supplies, x-rays, or other similar forms of health information. Regarding dependents under the age of 18: we will disclose health information based on the parent/guardian's signed authorization to persons listed on Authorization for Release of Protected Health Information form. This authorization will remain in effect until terminated by the patient or parent/guardian in writing.

Destruction of Protected Health Information: Our office is "paperless," meaning we only store patient health information electronically on our secure computer system. All hard copy patient forms are shredded on a regular basis.

Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.

Abuse, Neglect or Legal Proceedings: We are required by law to disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. In addition, we may disclose health information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request.

Contact Modes: We will use voicemail messages or answering machine messages, postcards, e-mails or letters if we cannot reach you personally. If we cannot speak with you directly, we will limit the information divulged as much as possible, except in matters of medical necessity.

Patient Rights: You have the right to view or obtain copies of your health information, with limited exceptions. If you request copies, you will be charged a reasonable fee per page, based on expense, such as copies, and staff time. You have the right to amend your information if you feel the information is incorrect or incomplete. You must submit your request in writing to our Privacy Officer. You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Health information should be amended as necessary. You should advise us when changes in your health occur.

Questions and Complaints: If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, or in response to a request you made to amend or restrict the use or disclosure of your health information, you may complain to us or may submit a written complaint to the U.S. Department of Health and Human Services.

Patient Signature: ______________________________ Date: ____________

I give consent to release information to the following person(s).

Name: ______________________________ DOB: ____________

Exam Room Guidelines

Pensacola Endodontics strives to achieve a clean, confidential, and safe environment for all our patients and staff. In order to reach and exceed our high standards of cleanliness and safety, we have adopted the following guidelines:

Cell Phone Use In the Exam Room

As a courtesy to other patients and the dental team, we ask that patients silence their cell phones while they are in the exam room.

Infants and Toddlers

For the safety and well being of your young child and our dental team, we do not allow infants or toddlers to accompany their parent or caretaker to the exam room. All children must wait in the waiting area. Children ages 11 and under require adult supervision at all times while they are in the waiting area.

Unscheduled Patients in the Exam Room

In order to provide personalized care to our patients confidentiality, we ask that only the scheduled patient be escorted back to the exam room. This allows our dental team to focus on the scheduled patient and maintain a safe, clean, and confidential environment.
We ask that all others wait in the waiting area.

Special Needs or Minors

Patients with special physical needs or minors (only if necessary) may be accompanied by one caretaker to the exam room.

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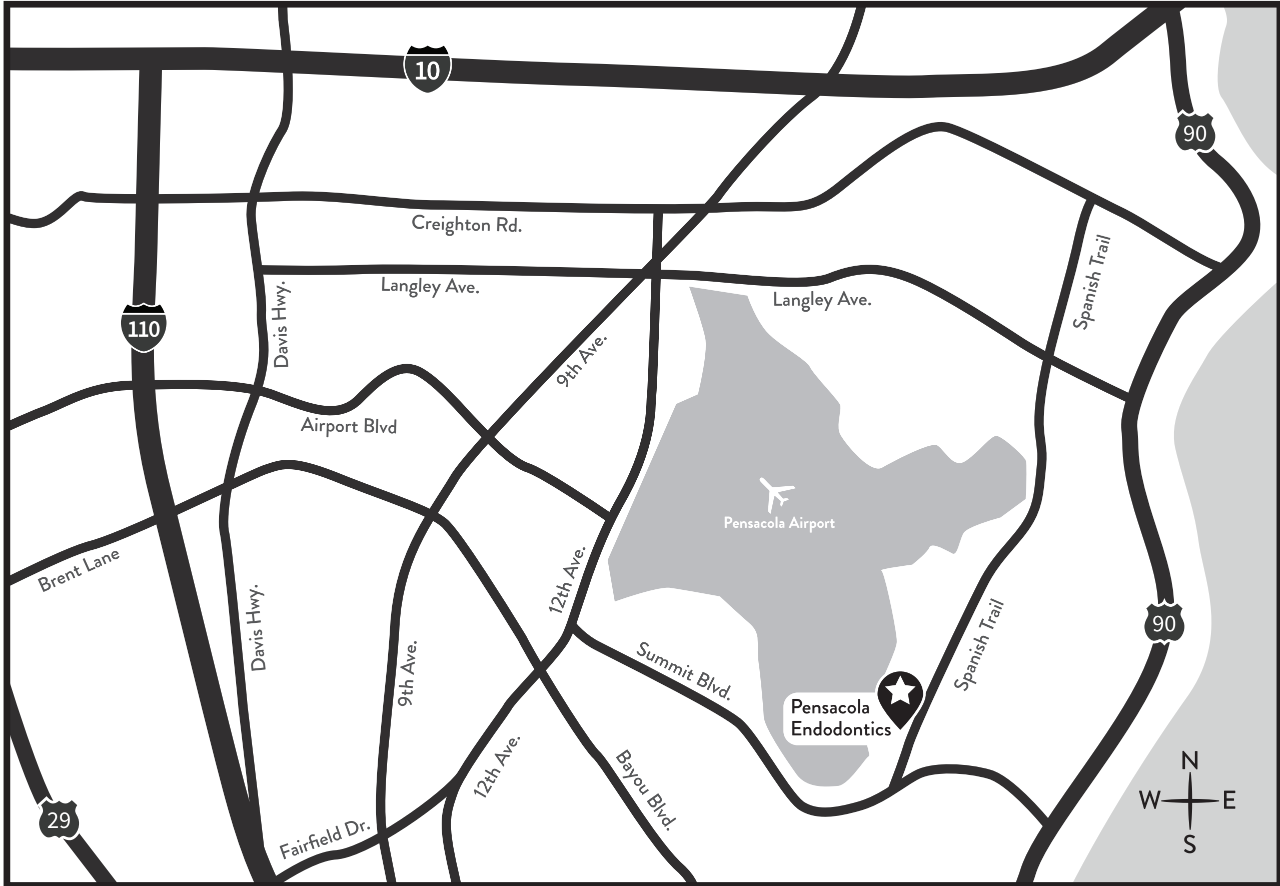
Pensacola Map



Office Location from Spanish Trail and Summit Blvd