PATIENT INFORMATION **Date:** ____/_____/_____ Name of general dentist: _____

Patient's Legal Name: _____ _____ Name called: _____

Date of Birth: _____/_____/_____ Age: _____ Social Security #: _____

Street Address: _____ City: _____ Zip: _____

Home Phone: (___) _____ Work Phone: (____) _____

Cell Phone: (___) _____ E-Mail Address: _____

Emergency contact/relationship: _____ Phone _____

Dental Insurance: Please give your **insurance card and driver's license** to front desk staff who will make copies

Insurance benefits are not always guaranteed. I agree to be responsible for any fees for services provided by this office.

Health Questionnaire

Please provide as much information as possible about your medical doctors:

Internist or primary care: _____ Phone: _____
Ob/Gyn: _____ Phone: _____
Cardiologist: _____ Phone: _____
Endocrinologist/Diabetes: _____ Phone:_____
Other: _____

Do you have any allergies/reactions to medications/substances? YES NO Please list:

_____

Please list all supplements, herbal, over the counter & prescribed medications you are taking:

_____

Have you tested positive for Covid-19, or know anyone who has? No Yes- test date: Yes- date of contact:

Do you pre-medicate prior to dental appointments with:

- **Antibiotics** for heart conditions or artificial joints? Y N
  type/amount:_____
- **Antianxiety** medication/herbs/supplements for dental anxiety? Y N
  type/amount:_____

How much anxiety do you have about dental treatment? None Mild Moderate Severe

What do you usually have for dental treatment?
__ Local anesthetic
__ Local anesthetic with nitrous oxide laughing gas
__ Sedation with valium or other medications that requires a responsible party drive me to my appointment.
__ Other

Patient name:_____ Age _____ Height _____ Weight _____

How long has it been since your last physical with blood work? 6 mo 12 mo 18 mo 24 mo or more

Women: Are you pregnant? **Y N** Do you take birth control pills? **Y N** Are you nursing? **Y N**

Do you use tobacco products? **Y N** What type?_____How much per day? _____

Do you have, or have you ever had any of the following conditions (circle Y (yes) N (no)?

Heart Defects	**Y N**	Month/Year corrected:_____ Not corrected
Heart Murmur	**Y N**	Type: _____
Heart Attack	**Y N**	Month/Year:_____
Heart Surgery	**Y N**	Month/Year:_____ bypass, stent, valve, oblation, other?
Pacemaker	**Y N**	Month/Year:_____
Angina Pectoris	**Y N**	Date of last episode: _____
Stroke	**Y N**	Month/Year: _____ full or partial recovery
High Blood Pressure	**Y N**	What is your normal/usual BP? _____ I don't know
Diabetes	**Y N**	Year diagnosed: _____ **Type:** 1 or 2
Liver disease	**Y N**	Type: _____
Hepatitis	**Y N**	Year diagnosed: _____ Type: A B or C full or partial recovery
Bleeding/blood dis.	**Y N**	Type: _____
Epilepsy or seizures	**Y N**	Date of last episode:_____
Fainting or dizziness	**Y N**	Date of last episode: _____
Cancer	**Y N**	Type: _____
Radiation therapy	**Y N**	Month/Year: _____
Chemotherapy	**Y N**	Month/Year:_____
Autoimmune disease	**Y N**	Type: _____
HIV	**Y N**	Year diagnosed: _____
Tuberculosis	**Y N**	Year diagnosed: _____
Osteoporosis	**Y N**	Month/year:_____ Treated with bisphosphonates: _____ No bisphosphonates
Joint replacement	**Y N**	Month/Year: _____ Type: _____
STD (sexually transmitted disease)	**Y N**	Year diagnosed: _____ Type: _____
Psychatric Condition	**Y N**	Year diagnosed: _____ Taking medication? Y N Type: _____
Alzheimers/Dementia	**Y N**	Year diagnosed: _____
Drug/Alcohol Addiction	**Y N**	Date last use: _____ Type: _____ Narcotics? _____
Thyroid Disease	**Y N**	
GI Conditions	**Y N**	Year diagnosed:_____ Type:_____ IBS,Colitis, Other?
Kidney disease	**Y N**	
Lung ulcers	**Y N**	
Emphysema or COPD	**Y N**	
Asthma	**Y N**	

Any other condition not listed? _____

I certify the above information is true and accurate. Thank you!

Patient/guardian signature: _____ Date: _____

Reviewed by Doctor: _____ Date: _____

Michael J. Binns DDS, PC
Root Canal Place

Consent Form for Endodontic (Root Canal) Treatment

Patient name: _____ Tooth #_____

I understand Dr. Binns is a general dentist who limits his practice to root canal treatment. I am satisfied with his qualifications and do not desire treatment by an endodontist.

_____ **Patient initials**

Root canal treatment is performed to save a tooth that might otherwise need to be removed. Root canal treatment is successful most of the time, but this cannot be guaranteed. At times a tooth that has had root canal therapy will require additional treatments to save the tooth such as surgery to remove infection around the root tip, surgery to increase the length of a badly broken down tooth, filling or post and crown. All recommended treatments must be completed to insure the best chance of success. Failure to do so will ultimately result in failure and probable loss of the tooth. I understand the above explanation and have had all of my questions answered to my satisfaction.

_____ **Patient initials**

There are certain risks associated with dental treatments. Complications may arise from use of dental instruments, chemicals, drugs and anesthetics (novacaine, lidocaine, etc). The most common complications that can arise with root canal treatment are swelling, sensitivity, pain, bleeding, infection, delayed healing, reactions to medications including dizziness, drowsiness, nausea, vomiting, rash, and allergic reactions. Nerve damage can also occur resulting in prolonged or permanent tingling or numbness in the lip, tongue, cheek, gum or teeth. Changes can occur in the way your teeth fit together resulting in loosening of teeth, jaw muscle cramps, joint difficulties, and pain in the teeth, ear, neck and head. Damage to the tooth, existing restorations, adjacent teeth & soft tissue can occur due to failure of dental instruments and other events such as broken/irretrievable files, chemical burns and severe tissue reactions & sinus perforation. All of these events can result in swelling, pain, infection, the need for additional treatment, and/or treatment failure and tooth loss. The most severe infections and reactions can be life threatening resulting in hospitalization. These most severe complications are possible, but rare. I understand the above explanation and have had all my questions answered.

_____ **Patient initials**

Other treatment choices include having no treatment or removing the tooth. Risks of these choices include but are not limited to pain, infection, swelling, tooth loss and infection to other areas of the body. In spite of the possible complications and risks, I desire the recommended treatment. I acknowledge that no guarantees have been made to me concerning the results of this treatment. I have had the opportunity to ask questions and receive satisfactory explanations for all of my questions about my condition, contemplated and alternative treatments, and the risks and potential complications associated with each of the contemplated and alternative treatments prior to signing this form.

_____ **Patient initials**

I hereby authorize the doctor and staff to perform all recommended and necessary treatment for me. I also authorize the use of radiographs, photographs, or videotapes of my case for use in presentations or publications by the doctor. I also give permission for Dr. Binns and his staff to discuss my drug and medical history with my personal doctors, dentists and pharmacists to discuss my complete drug and medical history and understand that narcotic prescriptions will not be provided if abuse is suspected.

_____ **Patient initials**

_____ _____
Patient or Guardian Signature Date

_____ _____
Reviewed by Dentist Date

Michael J. Binns DDS, PC
Root Canal Place

Statement of Patient Financial Responsibility

All account balances are due in full at the time of treatment unless other financial arrangements have been made in advance.

If you have dental insurance we ask that you pay the contracted fee for all treatments at the time of service. Our office will file an electronic claim on your behalf and give you a printed copy before you leave the office. Georgia law requires insurance to pay benefits within 10 days of receiving a claim and to provide an explanation of benefits (EOB) for all treatments paid and not paid. We instruct your insurance company to send all payments to you. If they should send payment to us, we will reimburse you as quickly as possible. Ultimately you are responsible for payment of all fees for services provided in our office.

I understand that I am ultimately responsible for all charges associated with my account and that if I fail to pay any amount due I will also be responsible for all collection fees, court costs, attorney and representative costs, accrued interest, and any other charges incurred in the delay or collection of any balance due.

I have read the above statements and accept the financial responsibility for the dental treatment for myself and any other individual for whom I am guarantor or guardian.

_____ _____
Patient Printed Name Date

_____ _____
Patient Signature Office Staff signature

NOTICE OF PRIVACY PRACTICES
Root Canal Place

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

Summary:
By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:
1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us.

If you have any questions about this Notice please feel free to ask.

Effective Date of this Notice: January 1, 2013

Acknowledgement of Notice of Privacy Practices:

"I hereby acknowledge that I have received a copy of this practice's *NOTICE OF PRIVACY PRACTICES.* I understand that if I have questions regarding my privacy rights that I may contact the office. I further understand that the practice will offer me updates to this *NOTICE OF PRIVACY PRACTICES,* should it be amended or changed in any other way."

_____
Patient or Representative Name (please print)

_____ _____
Patient or Representative Signature Date