ST. PETERSBURG ENDODONTICS

Legal Name_____ Preferred name_____ Birth date_____

Street or PO Box _____City_____State_____ZIP_____

Cell #_____Home #_____Driver License # _____

Employer_____ How Long_____ Work #_____

Referred by_____ Spouse_____ contact #_____

I agree to have any information regarding my personal health history or treatment notes communicated to my emergency contact in the event of a true emergency, to be determined by St. Petersburg Endodontics

Do not provide emergency contact if you do not agree to the above statement

Emergency contact _____Contact's relationship to you_____ contact #_____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL RECORDS:

Name: _____ Relationship: _____

Name: _____ Relationship _____

MEDICAL HISTORY

Heart and cardiovascular- YES or NO explain_____

Cancer YES or NO type_____ year_____ treatment_____

YES or NO AIDS, HIV, TB, hepatitis type_____, VD, herpes
Medication_____

YES or NO Liver or kidney disease
Medication_____

YES or NO High or Low blood pressure
Medication_____

YES or NO High or low Cholesterol
Medication_____

YES or NO Diabetes type_____ insulin dependent
Medication_____

YES or NO Fainting, seizures, epilepsy, migraines, black outs
Medication_____

YES or NO Ulcer, colitis, Crohn's, acid reflux, stomach trouble
Medication_____

YES or NO Psoriasis, eczema, lupus, Auto immune deficiency
Medication_____

YES or NO Addictions, Narcotic, alcohol, nicotine, caffeine
Other_____

YES or NO Osteoporosis or bone disease, bone replacement therapy
Medication_____

YES or NO Anemia, hemophilia, blood disorder
Medication_____

YES or NO Artificial- heart valve, knee, hip or other
Medication_____

YES or NO Thyroid condition, hyper or hypothyroidism
Medication_____

YES or NO Sinus surgery, drainage or trouble
Medication_____

YES or NO Asthma, emphysema, COPD, Oxygen dependent
Medication_____

YES or NO Antidepressants, anxiety, chronic fatigue, ADD
Medication_____

YES or NO Eye condition, glaucoma, cataracts, limited vision
Medication_____

YES or NO Arthritis, fibromyalgia, neuralgia, TMJ, joint problems
Medication_____

LATEX ALLERGY YES or NO Do you take a prescription blood thinner YES or NO **medication**_____

LIST ALL OTHER CONDITIONS OR MEDICATIONS NOT LISTED ABOVE_____

Are you allergic or sensitive to over the counter NSAIDS, examples- ibuprofen, naproxen YES or NO

List all allergeries_____

Have you been hospitalized or had a serious illness within the last 5 years YES or NO
If yes, explain_____

WOMEN are you pregnant or nursing? YES or NO *Please note that some antibiotics can lessen the effectiveness of contraceptives.

I have given a complete and accurate medical history.

Signature_____**Date**_____

Signature of guardian or representative_____**Date**_____

ST. PETERSBURG ENDODONTICS

-TELL US ABOUT YOUR SYMPTOMS-

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 symptoms? _____

Please check the frequency and quality of discomfort/intensity of your pain

LEVEL OF INTENSITY	CHRONOLOGY	QUALITY	AFFECTED BY
1=Mild 10=Severe	_Chronic	_Throbbing	_Hot _Cold
1_ 2_ 3_ 4_ 5_ 6_ 7_ 8_ 9_ 10_	_Lingering	_Sharp _Dull	_Air _Percussion
	_Intermittent	_Spontaneous	_Head Position _Activity
	_Momentary	_Steady	_Palpitation _Manipulation

Are you a patient that would need Nitrous Oxide for treatment done at our office? _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

Has this tooth had a root canal before? _Yes _No

Has root canal therapy been started on this tooth? _Yes _No

Any past trauma on this tooth? _Yes _No

Please describe trauma:

_____

_____

_____

Thank you!

St. Petersburg Endodontics

SUMMARY NOTICE OF PRIVACY PRACTICES

Legal Name (print) _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains participant rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office at (727)521.2285

You have the right to request that we restrict how protected information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke the Consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. St. Petersburg Endodontics provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The participant understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- St. Petersburg Endodontics has a Notice of Privacy Practices and that the participant has the opportunity to review this notice.
- St. Petersburg Endodontics reserves the right to change the Notice of Privacy Practices.
- The participant has the right to request restrictions to the uses of their information but St. Petersburg Endodontics does not have to agree to those restrictions.
- The participant may revoke this Consent in writing at any time and full disclosures will then cease.
- St. Petersburg Endodontics may condition receipt of treatment upon the execution of this consent.

I have received a copy of the Summary Notice of Privacy Practices.(available to all patients in a folder in the lobby) I understand that I may also request a copy of the practice's complete Notice of Privacy Practices if I so desire.

IN THE EVENT THAT ANY OF THE CONTACT INFORMATION THAT YOU HAVE PROVIDED TO ST. PETERSBURG ENDODONTICS CHANGES, IT IS YOUR RESPONSIBILITY TO INFORM OUR PRACTICE OF THE CHANGES. IN THE EVENT THAT YOU DID NOT INFORM OUR PRACTICE AND YOUR PHI (personal health information) IS BREACHED DUE TO THE OUTDATED INFORMATION, YOU WILL NOT HOLD ST. PETERSBURG ENDODONTICS LIABLE OR RESPONSIBLE.

_____

Signature

_____

Signature or Representative

(Required if participant is a minor or an adult who is unable to sign this form)

_____

NAME_____ DATE_____

Welcome to St. Petersburg Endodontics. By choosing our practice you have selected a practice whose doctors have demonstrated a high level of clinical excellence and state of the art technology.

Informed consent (Important to read before signing)

Our team would like you to be well informed prior to any treatment or services we provide to you. Your time, your questions and your concerns are very important to us. Our receptionist is here to handle financial, insurance and appointment questions. Our doctor and our assistants are here to answer your clinical questions.

Endodontics is a specialty practice that is limited to root canal therapy. In most cases we see patients one time on a referral basis. We strive to be accurate, honest and forth coming when it comes to our patient care. We would like our patients to be well informed about the various procedures involved in Endodontic (root canal) therapy and to have their consent before treatment. Endodontic therapy has a high degree of success but with any medical or dental therapy there is no guarantee of success for any length of time. The purpose of Endodontic treatment is to retain teeth that may otherwise have to be extracted. There are some teeth (very few) that do not respond to endodontic treatment. In spite of our best efforts, retreatment, surgery or extraction may be necessary. In many cases root canal therapy can be completed in one treatment, however this is not true for all cases. Therefore, we feel it is most important to treat each individual based on their needs. We believe in quality care so you may need to schedule a follow up appointment to finish your procedure. Due to the limitations of this specialty, we do not offer routine dental procedures such as cleanings, fillings or crowns.

Endodontic treatment is a very safe and has a high success rate. Success is influenced by the patient's immune system, tooth and canal anatomy that may be blocked or curved. On rare occasion some complications may include but are not limited to: pain, swelling, infection, prolonged numbness, reaction to injections, changes in bite, loss of filling or crown, fracture of porcelain, perforation, sinus perforation or temporomandibular joint pain. Additionally, the instruments used in endodontics are very delicate and occasionally break during the course of treatment. Normally instrument breakage does not affect the outcome but in rare cases, surgery or extraction of the tooth may be necessary.

Treatment alternatives: 1.) Extraction and replacement by an artificial tooth by means of a fixed bridge, dental implant, or a removable partial denture**. 2.)** NO TREATMENT Possible complications: conditions may worsen and may risk serious personal injury, including severe pain, localized severe pain, localized infection, loss of this tooth and possible other teeth, severe swelling, and/or severe infection that may spread to other areas and could potentially be fatal.

The final filling or restoration that covers the root canal treated tooth will need to be completed by your referring dentist and is not included in the fee for the root canal treatment. The final restoration should be done within 4-6 weeks of our completing your root canal**.** If I fail to have the tooth restored, I risk a failure of the root canal treatment, decay, infection, tooth fracture, and/or loss of the tooth.

I understand the above statement_____

Sign

St. Petersburg Endodontics
EMAIL AND COMMUNICATIONS

Legal Name_____Date_____

NOTE: If you elect not to provide an email, skip this section. Please understand that we cannot allow for any future communication via email if you elect to skip this section.

1.When we send you an email, or you send us an email, the information that is sent **is not encrypted**. This means a third party may be able to access the information and read it since it has been transmitted over the internet. In addition, once the email is received by you, someone may be able to access your email account and read it.
2. Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPPA act, the federal government provided guidance on email and HIPPA.
3. The information is available in a pdf (page 5634) on the US Department of Health and Human Services website https://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf- (available for viewing at front desk)
4. The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

Allow unencrypted email
I understand the risks of unencrypted email and do hereby give permission to St. Petersburg Endodontics to send me personal health information via unencrypted email

_____ _____
Signature Email

SECTION B:

I AUTHORIZE AND CONSENT THAT MY DENTAL HEALTH INFORMATION, CONFIRMATION OF APPOINTMENTS, TREATMENT NOTES & BILLING BE CONVEYED VIA:

- ☐ Voice Message on telephone number that I provided
- ☐ Text Message on Cell phone
- ☐ Email that I provided above
- ☐ Home or PO box mailing address I provided when filling out my paperwork
- ☐ **Any of the above**

_____
Signature