New River Valley Endodontics

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140 East Main Street, Suite A
Radford, VA 24141

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (H) _____ (W) _____ (C) _____

Sex: ☐ M ☐ F Social Security #: _____

Date of Birth: _____

Employer: _____

Occupation: _____

Referred By: _____

General Dentist: _____

Dental Insurance Company: _____

Insurance Address: _____

Insurance Phone #: _____

Group #: _____ ID #: _____

Relationship to Insured: ☐ Self ☐ Spouse ☐Child

IF INSURANCE IS OTHER THAN SELF, PLEASE FILL IN THE FOLLOWING:

Subscriber Name: _____

Date of Birth: _____ Social Security #: _____

Employer: _____ Work Phone #: _____

The above information is true to the best of my knowledge.

Signature: _____ Date: _____

Responsible Party if Patient is a Minor: _____

CONFIDENTIAL DENTAL-MEDICAL HISTORY FORM

Dental:

Last Dental Exam: _____ Are you apprehensive about dental treatment? ☐ Yes ☐ No

Medical:

Do you have any current health problems? ☐ Yes ☐ No

Are you under a physician's care now? ☐ Yes ☐ No

If yes, for what? _____

Current Medications: _____

_____

Medical Alerts: _____

Medical History: _____

Check any of the following that you have had or suspected:

____Arthritis	____Hepatitis or Jaundice	____Fainting Tendency
____Rheumatic Fever	____Liver Disease	____Epilepsy
____Heart Trouble/Disease	____Cancer or Tumor	____Thyroid Disease
____Heart Murmur	____Tuberculosis	____Glaucoma
____Heart Pacemaker	____Diabetes	____Kidney/Bladder Trouble
____High/Low Blood Pressure	____Chest Pain	____Anemia
____Radiation Treatment	____Stroke	____Lung Disease
____Mental Disorders	____Shortness of Breath	____Venereal Disease
____HIV or AIDS	____Asthma or Hay Fever	____Blood Disease
____Joint Replacement	____Sinus Trouble	____Bruise Easily
____Mitro Valve Prolapse	____Emphysema	
____Blood Transfusion	____Prolonged Bleeding	

Check any of the following that you are taking or have taken:

____Cortisone Drugs	____Anticoagulants	____Tranquilizers
____Steroids	____Blood Thinners	____Sedatives

Are you allergic to or do you suffer ill effects from any of the following?

____Penicillin	____Erythromycin	____Codeine
____Dental Anesthesia	____Aspirin	____Household Bleach
____Nitrous Oxide	____Other: _____	

Women Only: Are you pregnant? ☐ Yes ☐ No

Are you presently taking medicine of any kind routinely? ☐ Yes ☐ No
(Ex: Birth control pills, shots, implant, or hormone therapy etc.)

Explain: _____

Is there any other medical or dental information I need to know about? ☐ Yes ☐ No

If Yes: _____

Family Physician: _____ Phone #: _____

The above information is true to the best of my knowledge.

Signature: _____

Responsible Party if Patient is a Minor: _____

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Statement of Office Policy/Consent for Payment

Patients without Insurance:

1. As services are rendered: For those patients without insurance, the full balance is due at time of treatment
2. Credit Cards: We accept Visa, MasterCard, and Discover.

Patients with Insurance:

1. Traditional Insurance: If you have dental insurance, we will be happy to file it for you and have the insurance company pay us directly. You will be responsible for any portion of the fee that is not covered by your insurance company, and this portion will be due at the time of service. All insurance will be verified to the best of our abilities before treatment begins to determine your benefits. Most insurance companies cover approximately 50-80% of our fee. If we can NOT determine your benefits, we will collect the entire amount of the treatment fee from you at the first appointment. We will still be happy to submit your claim for payment and send you a refund or you may choose to submit the claim yourself for reimbursement.
2. Credit Card: We accept Visa, MasterCard, and Discover

If the insurance company does not pay the remaining amount, even after verification, we will send you a statement. If the statement is not paid in full by the date listed, service charges of 1.5% per month will be added. If payment is not made, your account will be turned over for collection. You will be responsible for any and all cost associated with the collection process, including but not limited to billing cost, collection fees, lawyer fees and court costs.

Please take a moment to read the following information very carefully:

- **Additional fees apply for retreatments, buildups or additional canals that may be found during treatment.**
- **The fee does not include the final restoration (such as a crown). This is handled by your general dentist.**
- **The fee does not include other procedures that are not currently apparent but which may be essential to the completion of the root canal therapy.**
- **Payment in full is expected if you do not have insurance or if insurance cannot be verified.**
- **Payment is expected at time of service on any amount the insurance does not cover, after verification. If a balance remains after insurance payment is received, the amount is due promptly.**

I certify that I have read and understand the above policy and that I accept the terms within. I understand that I am responsible for any and all fees that are incurred in this office and those which are not covered by my insurance company.

Signature of Patient or Legal Guardian: _____

Date: _____ Office: _____

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Informed Consent for Treatment

Today I will receive endodontic care (root canal therapy). I understand that root canal therapy consists of procedures aimed toward the preservation and retention of teeth which might otherwise require extraction. There is a high degree of clinical success, but since it is a biological procedure, results cannot be guaranteed. **Possible unavoidable complications of root canal procedures include but are not limited to:** swelling, soreness, fracture of the crown or root of the tooth, separation of root canal instruments during treatment, blocked canals due to fillings, prior treatment or severe calcification, perforation of the crown of root of the tooth, damage to existing crowns or bridges. Occasionally, a tooth that has received a root canal filling will require retreatment, surgery or extraction.

I understand the administration of Local Anesthetic will be used for this procedure. I understand that with the use of local anesthetic there is a possibility of one or more of the following complications; numbness of the lip/or tongue for an undefined period or permanently, soreness as well as some discoloration of the injection site, or severe reaction to the drugs administered.

Patient Signature: _____ Date: _____