Getting to Know you - New Patient Registration

New Patient Account Information

Patient Information

Patient Name (First, Last)	Sex ❑M ❑F	Age	Birthdate

Home Address	City, State, Zip	Home Phone ( )
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated	Social Security #	Cell Phone ( )
Employer	Phone Number	Occupation

Emergency Contact Information

Name (First, Last)	Relationship to Patient	Phone Number ( )

Responsible Party Information

Individual Responsible for Patient Account: (Please ☑ one)

❑ Self ❑ Spouse ❑ Parent ❑ Guardian ❑ Other, please specify: _____

Name (First, Last)		Birthdate
Home Address	City, State, Zip	Phone ( )
Responsible Party's Employer		
Employers Address	City, State, Zip	Work Phone ( )

Method of Payment (Please ☑ one)

❑ Cash ❑ Check ❑ Visa ❑ American Express ❑ Mastercard ❑ Discover ❑ Care Credit

Financial Consent and Terms and Conditions

➡The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental services performed without prior financial arrangements must be paid for at the time the services are performed.

➡I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making claims and will credit such collections to my account. However, this dental office is fee for service based and cannot render services on the assumption that charges will be paid by an insurance company. Therefore, I understand my patient account with this office is solely my responsibility and all financial obligations to this office belong to me, the patient listed.

➡I agree to the terms and conditions listed above and verify that all the above information I have entered on this document is complete and true to the best of my knowledge.

_____ _____

Signature of Patient or Parent/Guardian Date

Getting to Know you – New Patient Registration

Health History Questionnaire

To ensure your well-being while undergoing treatment in our office, please answer the following questions in detail. Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. All answers will be held in strict confidence. Personal medical records will not be released to anyone without your written authorization.

Patient Name (First, Last)	Date of Birth / /	Age

Why have you come in to see us today? (E.g. infection, consultation, etc.)

Are you nervous about your visit today? (Please ☑ the box) ❑No ❑Yes	If yes, is there anything we can do to help you feel more comfortable during your visit? ❑No ❑Yes If yes, explain:

Patient Dental History (Please ☑ the box)

Referring Dentist Name	Address	Home/Cell Phone ( )

Have you had any serious medical complications occur during or resulting from any dental procedures in the past? ❑No ❑Yes If yes, explain:

Patient Medical History (Please ☑ the box)

Physicians Name	Address	Home/Cell Phone ( )

Are you currently under a physician's care? ☑	❑No ❑Yes	Are you currently taking or have you taken Bisphosphonates for Osteoporosis? ☑	❑No ❑Yes	Do you have an allergy to any of the following items? (please ☑)	
Do you use any tobacco products? ☑	❑No ❑Yes	If yes, how many per day?		❑No ❑Yes	Aspirin
Are you taking prescription medications? ☑	❑No ❑Yes	If yes, please list:		❑No ❑Yes	Metal
Do you have a history of substance abuse or do you currently use recreational drugs? ☑	❑No ❑Yes	If yes, please explain:		❑No ❑Yes	Penicillin
				❑No ❑Yes	Latex
Have you been told you need to be pre-medicated before dental treatment? ☑	❑No ❑Yes	If yes, please explain:		❑No ❑Yes	Codeine
				❑No ❑Yes	Sulfa Drugs
Are you currently taking anti-coagulant medications? (e.g.: Coumadin, Warfarin) ☑	❑No ❑Yes	If yes, please explain:		❑No ❑Yes	Acrylic
				❑No ❑Yes	Local Anesthetics
Have you ever been hospitalized or had a major surgery? ☑	❑No ❑Yes	If yes, please explain:		Other? _____	

Do you Currently or Have you Had Any of the Following? (Please ☑ the box)

❑No ❑Yes	AIDS or HIV Infections	❑No ❑Yes	Emphysema	❑No ❑Yes	Liver Disease	❑No ❑Yes	Anemia
❑No ❑Yes	Epilepsy/Seizures	❑No ❑Yes	Low Blood Pressure	❑No ❑Yes	Angina (Chest Pain)	❑No ❑Yes	Fainting
❑No ❑Yes	Osteoporosis	❑No ❑Yes	Arthritis/Gout	❑No ❑Yes	Glaucoma	❑No ❑Yes	Pain in Jaw Joint
❑No ❑Yes	Artificial Heart Valve	❑No ❑Yes	Heart Attack	❑No ❑Yes	Psychiatric Care	❑No ❑Yes	Artificial Joint Replacement
❑No ❑Yes	Heart Pacemaker	❑No ❑Yes	Radiation Therapy	❑No ❑Yes	Asthma	❑No ❑Yes	Hepatitis/Jaundice
❑No ❑Yes	Shingles	❑No ❑Yes	Cancer	❑No ❑Yes	Herpes (Cold Sores)	❑No ❑Yes	Stroke
❑No ❑Yes	Chemotherapy	❑No ❑Yes	High Blood Pressure	❑No ❑Yes	Tuberculosis	❑No ❑Yes	Convulsions
❑No ❑Yes	Kidney Disease	❑No ❑Yes	Ulcers	❑No ❑Yes	Diabetes, Type_____	❑No ❑Yes	Leukemia
❑No ❑Yes	Other:	Have you ever had any serious illness not listed? ❑No ❑Yes				If yes _____	

For Women Only: (Please ☑ the box)

Are you pregnant or may be pregnant? ❑No ❑Yes Are you taking oral contraceptives? ❑No ❑Yes Are you breastfeeding? ❑No ❑Yes

Patient Health History Acknowledgment

The above medical history is complete and true to the best of my knowledge.

_____ Signature of Patient or Parent/Guardian	_____ Date:

INFORMED CONSENT FOR ENDODONTIC THERAPY

❖WHAT IS ENDODONTIC TREATMENT?❖

ENDODONTIC THERAPY IS PERFORMED IN ORDER TO TRY TO SAVE A TOOTH WHICH OTHERWISE MIGHT NEED TO BE REMOVED.
ENDODONTIC TREATMENT *involves the administration of local anesthetic, and then a rubber dam is placed over the affected/infected tooth. With the assistance of a microscope, the Endodontist creates an opening in the biting surface of the tooth. Then, with great precision, using a specialized filing system, the doctor removes the micro-sized, affected/infected nerve from the canal(s) in the tooth.*
FOLLOWING THE REMOVAL OF THE NERVE(S), *the doctor flushes the canal with solutions, prepares the canal for sealing then inserts a filling material (gutta percha), which is measured, trimmed and placed in the canal(s) completing the root canal treatment.*

UPON COMPLETION OF THE ROOT CANAL TREATMENT, I AM TO RETURN TO MY DENTIST FOR PERMANENT RESTORATION. I SHOULD SCHEDULE THIS APPOINTMENT WITHIN 1 MONTH TO AVOID FURTHER DAMAGE TO THE TOOTH*

❖TREATMENT ALTERNATIVES❖

I UNDERSTAND there are alternatives to Endodontic Therapy. They include, but are not limited to:

- *No treatment. The condition will worsen with time and may include pain, infection, and loss of tooth.*
- *Extraction with nothing to fill the space. This may result in a change in the bite, loss of function, and gum disease.*
- *Extraction followed by a bridge, partial denture, or implant to fill the space.*

❖POTENTIAL RISKS OR COMPLICATIONS❖

I UNDERSTAND there are potential risks and complications in any treatment. They can include, but are not limited to the following:

- *Postoperative discomfort lasting a few hours to several days, usually related to how sore the tooth was before treatment.*
- *Postoperative swelling or infection, usually related to the severity of the swelling/infection before treatment.*
- *Failure rate of 5-10% under optimal conditions. If failure occurs, additional treatment will be required such as: retreatment, endodontic surgery or extraction of the tooth. Retreatment failure rates are higher, but vary due to the reason for the failure.*
- *With some teeth, conventional Endodontic Therapy may not be sufficient and additional treatment may be required in instances such as:*
  - a) *If the canals are severely curved, blocked, or split such that they cannot be treated.*
  - b) *If an instrument separates in the tooth during treatment.*
  - c) *If periodontal disease is present or a problem for which periodontal treatment may be needed.*
  - d) *Pre-existing fractures, severe infections or cysts, or perforations of the root, tooth, or sinus.*
  - e) *Restoration damage such as porcelain fracture while preparing the opening in the crown.*
    NOTE: *If damage occurs, often it can be repaired while in other cases the crown may require replacement.*
  - *f) Premature loss of the tooth due to progressive periodontal disease.*
  - g) *Complications resulting from the use of instruments, materials, medications, anesthetics, and injections.*

❖IMPORTANT NOTE REGARDING TREATMENT COMPLETION❖

ONCE TREATMENT HAS BEEN STARTED, *it is absolutely necessary that the root canal treatment be completed. One or more appointments may be required to complete treatment. It is the patient's responsibility to seek attention should any unanticipated or undue circumstance occur. Also, the patient must diligently follow any and all pre-operative and/or post-operative instructions prescribed by the Endodontist.*

❖INFORMED CONSENT❖

FOLLOWING TREATMENT, my tooth often will require an additional restoration where a filling and/or crown is placed on the treated tooth. I understand that if I neglect to return to my dentist for proper restoration within one month post treatment, there will be an increased risk of:

- ***Root Canal treatment failure***
- ***Infection that may require retreatment of the tooth***
- ***Fracture of the tooth and/or premature loss of the tooth***

I understand that I may be asked to return to this office for follow up visits, to be evaluated and assessed for optimal healing.

IN SIGNING THIS DOCUMENT, *I acknowledge that I have provided an accurate medical history, will follow treatment recommendations. I understand I will have the opportunity to ask any questions concerning the risks in continuing with root canal treatment. Dr. Campbell will explain to me the diagnosis, method and manner of the proposed procedure(s), the risks of treatment vs. no treatment, prognosis, and feasible alternatives. I understand this document does not encompass the entire discussion I had with the doctor regarding the proposed treatment. I will be given the opportunity to ask any questions regarding the nature and purpose of root canal treatment and all questions or concerns answered to my satisfaction. I voluntarily assume any and all possible risks, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. I understand that root canal treatment is an attempt to save a tooth that would otherwise be lost. Although root canal treatment has a very high degree of success, it cannot be guaranteed. Reputable practitioners cannot guarantee results.*
I reserve the right to refuse treatment if after case discussion with the doctor I do not want the recommended treatment. I also understand full payment is due at the time of completion of the treatment unless other arrangements have been made.

Name of Patient (printed)	Signature of Patient or Parent/Guardian	Date
Witness Name (printed)	Signature of Witness	Date

Getting to Know you - New Patient Registration

Authorization for Release of Information

Name of Patient (First, Last)	Date of Birth

CARY ENDO (Steven W. Campbell, DMD) is authorized to release protected health information about the above-named patient in the following manner and to the identified persons listed below:

Entity to Receive Information (*Check each person/entity that you approve to receive information.*)	**Description of Information to be Released** (*Check each to be given to person/entity on the left in the same section.*)
❑ Spouse ❑ Parent/Guardian ❑ Other Name	❑ Financial ❑ Dental Treatment/Appointment Reminders
❑ Voicemail Message _____ (Phone)	❑ Results of lab tests/x-rays ❑ Other_____
❑ Email Communication **(***see* ***NOTE** *below***):** _____.com	❑ Financial ❑ Dental Treatment/Appointment Reminders ❑ Breach Notification

***NOTE**: In order for our office to send email communication to our patients, you must read and accept the disclosure below. If you accept the terms, please sign your initials in the box next to the disclosure.

Initials	I consent to receiving email from CARY ENDO in understanding that if e-mail is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email communication from this office at the e-mail address above.

❑ Communication about treatment alternatives even if this office is being compensated for making the communication.

Patient Rights:

- I have the right to revoke this authorization at any time by submitting a signed, written request to CARY ENDO, revoking this consent.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The selected information is released at my request. I am aware that this authorization will remain in effect until I notify this office in writing that I revoke my consent.

Signature of Patient/Parent/Guardian/Representative	Representative Relationship to Patient?	Date

Dr. Steven Campbell
1400 Crescent Green Drive, Suite 200
Cary, North Carolina 27519
(919) 233-8830
admin@caryendo.com

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say “no” to your request, but we’ll tell you why in writing within 60 days.

continued on next page

Your Rights *continued*

Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures after April 14, 2003, except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases, we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

continued on next page

Our Uses and Disclosures
- continued

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: April 14, 2003

Getting to Know you - New Patient Registration

Acknowledgement Receipt for Notice of Privacy Practices

Patient Name (First, Last)	Birthdate (mo/da/yr)

I acknowledge that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have been informed of the "***CARY ENDO***" *Statement of Privacy Practices* containing a more complete, detailed description of the uses and disclosures of my protected health information. The *Statement of Privacy Practices* describes in detail the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services or in the performance of office health care operations. The *Statement of Privacy Practices* also describes my rights and the responsibilities and duties of this office with respect to my protected health information.

I have been given the right to review and receive a copy of such *Statement of Privacy Practices*. ***CARY ENDO (Dr. Campbell)*** reserves the right to change the privacy practices that are described in the *Statement of Privacy Practices*. I may contact their office at any time to request a copy of the current *Statement of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

My signature confirms that I have been informed of my rights to privacy under HIPPA. I have also indicated any other persons, if any, I would allow to have access to my personal health information in the space below.

_____

Signature of Patient or Legal Guardian

_____

Date

_____

Relationship to Patient

❖For Office Use Only❖

Record of Acknowledgement:

Provided prior to Treatment? ☐Yes ☐No Date Provided: ___/___/___ By (initial): _____

Record of Acknowledgement Not Obtained:

Reason for Denial:

- ☐ Needed more time to review *Statement of Privacy Practices*
- ☐ Wanted to consult with another person before signing
- ☐ Communication barrier
- ☐ Emergency situation
- ☐ Reason not given
- ☐ Other (explain): _____