EASTERN SHORE ENDODONTICS
TRES H. MANASCO, D.M.D., P.C.

ACQUAINTANCE SLIP

Patient's Name _____ Date of Birth _____

Address _____ Phone _____

City & State _____ Zip Code _____

Employer _____ Dept. _____

Employer's Address _____

_____ Phone _____

Your Social Security # _____

Does your employer provide Dental Insurance? _____

If so, Name of Insurance Company? _____

Policy # _____

◆ ◆ ◆ ◆ ◆

Spouse's or parent's Name _____

Employed by _____ Dept. _____

Employer's Address _____

_____ Phone _____

Social Security # _____

Does this employer provide Dental Insurance? _____

If so, Name of Insurance Company? _____

Policy # _____

Birthdate of Insured _____

PLEASE TURN TO BACK OF THIS SHEET TO ANSWER THE REQUIRED MEDICAL QUESTIONS

HEALTH HISTORY

Information about your health will be held as confidential by this office and will be released upon your expressed consent. Many general health factors may affect your oral health and influence our treatment. Therefore, it is important for you to complete this form accurately and in its entirety. Thank you.

1. General health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

   Physician's Name _____

2. Please circle any of the following you have or have had:

Artificial Heart Valve	Heart Murmur	Asthma	Fainting
Prosthetic Implants	High Blood Pressure	Diabetes	Nervous Disorder
Mitral Valve Prolapse	Hepatitis	Liver Disease	Prolonged Bleeding
Rheumatic Fever	Tuberculosis	Kidney Disease	Heart Attack
AIDS/HIV	Cancer/Malignancy	Radiation Treatment	Epilepsy or Seizures

	YES	NO
3. Do you have a pacemaker?	☐	☐
4. Have you had, or do you have any medical problem NOT mentioned above? (If yes, please describe.)	☐	☐
5. Are you now being treated by a physician?	☐	☐
6. Do you take any drug/medication for your tooth or a medical problem? If yes, please list:	☐	☐
7. Are you allergic to penicillin, codeine or any other drug? If yes, please list:	☐	☐
8. Are you allergic to latex?	☐	☐
9. Have you experienced an unfavorable reaction from any previous dental treatment?	☐	☐
10. Have you ever had Root Canal Treatment?	☐	☐
FEMALES		
11. Are you pregnant?	☐	☐

Patient's
Signature _____ Date _____

If the patient is a minor:
Parent's Signature _____

I give permission for examination and endodontic treatment for my minor child, named above.

OUR PAYMENT POLICY

The best patient-doctor relationships are maintained when there is a complete understanding of the treatment rendered and the fee. We feel that our work and equipment are of the highest quality. Our objective is to free you of pain in minimal time.

It is our policy that ½ payment be made at the first visit, and the remaining ½ of the total be paid at the second visit. If all work is completed in one visit total payment is required. The responsible party agrees to pay any collection fees (attorney fees and court costs) required in the process of collecting a delinquent account plus interest in the amount of 18% APR for accounts delinquent more than 60 days.

Your method of payment (check one):

____ I will pay in full now

____ I will pay ½ now and the balance at the second visit

____ Mastercard/VISA

Insurance: this office will submit your insurance form for you. However, most insurance companies do not provide full coverage for root canal therapy. Therefore, we ask that you pay ½ of the total fee to our office by the day of completion of treatment. The patient, not the insurance company, is responsible for payment of fees to this office. This form also authorizes your insurance carrier to issue the dental benefits of your plan directly to this office and release any information necessary to process your dental insurance.

Signed: _____

Date: _____

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ENDODONTIC (ROOT CANAL) INFORMED CONSENT

1. The purpose of root canal therapy is to retain teeth that otherwise would have to be extracted (pulled).
2. Treatment will require a series of x-rays and may require multiple visits. It is important that you keep scheduled appointments, or infection may reoccur.
3. In most cases, there is only mild discomfort after treatment. This usually lasts 2-4 days and is usually controlled by ibuprofen, aspirin, Tylenol or a prescribed medication.
4. Endodontic therapy has a high rate of success (approximately 90-95%). However, as with any medical or dental treatment, there is no guarantee of success for any length of time.
5. Most common complications include but are not limited to:
    a. Continued infection requiring Endodontic surgery or tooth extraction at an additional cost.
    b. Calcified canals or canals blocked by separated instruments requiring Endodontic surgery or tooth extraction at an additional cost.
    c. Pain requiring use of medications.
    d. Fracture (breaking) of the root or crown of the tooth during or after treatment. It is recommended that teeth be crowned (capped) following root canal treatment. If your tooth already has a crown it may have to be replaced due to decay or loss of structural support. Porcelain crowns are subject to breakage and may also have to be replaced.
    e. Side effects and possible reactions to medications.
    f. Tenderness of the tooth following treatment, due to possible complications with root canal treatment, gum disease, physical stress from chewing or the degree of healing your body exhibits.
6. The permanent restoration of your tooth (filling, crown, bridge, onlay, etc.) will be performed by your General Dentist (our fee does not include these services.)
7. Other treatment choices include:
    a. No treatment
    b. Waiting for more definite development of symptoms
    c. Tooth extraction (pulling)
    ***Risks involved in these choices may include pain, infection, swelling, loss of teeth and possible spread of infection to other areas.
8. If you have any questions please ask!

"I have read and understand the above information, and understand the possible risks involved, and hereby consent to treatment."

Signature of patient or parent _____ Date _____

Staff _____ Date _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____
_____
_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/14/2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: 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.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

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

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may 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.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0. 75 for each page. $ 15 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: 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).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

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 or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: _____

Telephone: _____ Fax: _____

E-mail: _____

Address: _____
