LexingtonEndodontics
Gregory A Carman, DMD
Jacob N Weigle, DMD

PATIENT INFORMATION

Today's Date ____/____/____

Email ________________________________

Patient's Name ________________________________
First MI Last

Sex ☐ M ☐ F Date of Birth ____/____/____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Address ________________________________
Street City State Zip

Phone # (____) __________ (____) __________ (____) __________
Home # Work # Mobile #

Social Security # __________ Employer __________
Name

Occupation __________ Insurance Company __________

Insurance Subscriber Information ________________________________
Name DOB SSN

Contact in case of emergency ________________________________ (____) __________
Name Relationship Phone #

PATIENT PRIVACY (HIPAA):

I understand that I have certain rights to privacy regarding my protected health information and have received a copy of these rights. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to provide treatment.

Patient, Parent or Guardian Signature ________________________ Date ____/____/____

FINANCIAL POLICY / DENTAL INSURANCE:

I agree to assume financial responsibility for treatment costs and understand payment is due in full at the time of treatment, unless other arrangements have been made. If I have dental insurance, my portion of the treatment costs are required at the time of treatment, I understand that if my dental insurance company rejects paying for treatment I will assume full responsibility for the account balance. **I understand that any estimate of my treatment cost given for my portion is simply an estimate and may fluctuate depending on my insurance companies usual and customary fees.** In case of default of payment, patient or responsible party agrees to pay all cost of collection including attorney fees, collection fees, and contingent fees to collection agencies up to 40%, such contingency fee to be added and collected by the collection agency. In the case of a court action, the patient or responsible party is responsible for any court cost, serving fees, or attorney fees.

Patient, Parent or Guardian Signature ________________________ Date ____/____/____

AUTHORIZATION TO TREAT:

I authorize this office to perform diagnostic procedures (examination, x-rays, study models and photographs) deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize this office to perform any agreed upon treatment needs.

Patient, Parent or Guardian Signature ________________________ Date ____/____/____

INFORMED CONSENT FOR ROOT CANAL THERAPY, RETREATMENT, OR APICOECTOMY:

I understand that although endodontic treatment is generally very successful, and every effort will be made to ensure success, no guarantee of success has been made. Despite the best efforts of Dr. Carman, I understand that if root canal therapy or retreatment is not successful Apicoectomy (root end surgery) or removal of the tooth could still be required. I assume these risks and choose to undergo endodontic treatment in lieu of removal of the tooth or other tooth replacement options including dental implants, fixed bridges, etc.

Patient, Parent or Guardian Signature ________________________ Date ____/____/____

LexingtonEndodontics
Gregory A Carman, DMD
Jacob N Wagie, DMD

Medical and Dental History

Patient's Name ______________________________ Date of Birth _____/_____/_____

General Dentist's Name ______________________________

Have you ever taken or are you currently taking any bisphosphonates such as Zometa, Fosamax, Aredia, Actonel, Boniva Didronel, Skelid, Bonefos, or Alendronate? ☐ Yes ☐ No

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Sulfa Drugs ☐ Codeine ☐ Latex or Rubber ☐ Other ______________________________

Please list the medications you are currently taking. ______________________________

____

____

MEDICAL HISTORY

Please check "yes" if you presently have or have had in the past any of the following conditions:

Yes

- ☐ Atrial Fibrillation
  - ☐ Tachycardia ☐ Bradycardia
  - ☐ Other: ______________
- ☐ Recent Chest Pain
- ☐ Heart Attack (Date: ______________)
- ☐ Congenital Heart Disorder
- ☐ Mitral Valve Prolapse*
- ☐ Artificial Heart Valve*
- ☐ Heart Pacemaker*
- ☐ Heart Surgery (Date: ______________)
- ☐ Stroke (Date / Type: ______________)
- ☐ Aneurysm (Date: ______________)
- ☐ High Blood Pressure
- ☐ Cancer (Date / type: ______________)

Yes

- ☐ Lung Disease (Type: ______________)
- ☐ Asthma (Date of Last attack: ________)
- ☐ Hepatitis ☐ B or ☐ C
- ☐ HIV Positive or AIDS
- ☐ Sexually Transmitted Diseases (Type: ______________)
- ☐ Bleeding Disorder (Type: ______________)
- ☐ Blood Transfusion (Date: ______________)
- ☐ Currently Pregnant (# of months ______________)
- ☐ Headaches ☐ Migraines ☐ Cluster
  - ☐ Tension ☐ Sinus
  - ☐ Other: ______________

Yes

- ☐ Tuberculosis (TB)
- ☐ Epilepsy
- ☐ Depression ☐ Anxiety
- ☐ Bipolar ☐ ADD ☐ OCD ☐ Schizophrenia
- ☐ Liver Disease (Type: ______________)
- ☐ Artificial Joint* ☐ Knee ☐ Hip
  - ☐ Other: ______________
- ☐ Stomach or Intestinal Disease (Type: ______________)
- ☐ Thyroid Disease ☐ Hypo ☐ Hyper
- ☐ Kidney Disease (Type: ______________)
- ☐ Diabetes – NIDDM or IDDM (HBA1C: ______________)

Please list any disease or condition not listed above, or use the space provided to explain conditions listed above. ______________

____

DENTAL HISTORY

Where is the problem? ☐ Upper Right ☐ Lower Right ☐ Upper Left ☐ Lower Left ☐ Upper Front ☐ Lower Front

How long has the present problem been going on? ____ Days ____ Weeks ____ Months ☐ Over a Year

Is the problem ... Getting worse? ______ Getting better? ______ Staying the same? ______

Check any symptoms you currently have:

☐ Pain with Heat ☐ Pain to Bite ☐ Pain to Pressing on Gum
☐ Pain with Cold ☐ Fever ☐ Pain to Pressing on Tooth
☐ Wakes from sleep due to pain

Type of Pain: ☐ Constant ☐ Intermittent ☐ Radiating ☐ Sharp ☐ Dull

Rate your pain on a scale of 1 through 10 with 1 = very little pain to 10 = very severe pain. Present pain ________ Past Pain ________

Rate your anxiety about today's treatment on a scale of 1 through 10 with 1 = very little anxiety to 10 = very severe anxiety. ________

Do you have a problem with a gag reflex? Please rate it on a scale of 1through 10 with 1 = no gag reflex to 10 = very severe. ________

Have you ever been told of the need for a night guard / bite guard? ☐ Yes ☐ No Do you currently wear one? ☐ Yes ☐ No

Are you on an antibiotic currently? If so, check the one that applies.... ☐ Penicillin ☐ Amoxicillin ☐ Clindamycin ☐ Keflex ☐ Azithromycin ☐ Other ______________

To the best of my knowledge, all of the preceding answers are true and accurate. If I (or my child) ever have any change in health status or medications being taken or if I (or my child) have any abnormal medical test results, I will inform the dentist at the next appointment without fail.

Patient, Parent or Guardian Signature ______________________________ Date ______________

FOR OFFICE USE ONLY

☐ Letter / X-ray ☐ Letter Only ☐ No Letter ☐ Email ☐ Post Treatment Instructions Received ________

LexingtonEndodontics
Gregory A Carman DMD
[illegible], DMD

620 Perimeter Drive, Suite 103
Lexington, KY 40517
859.268.7668

NOTICE OF PRIVACY PRACTICES

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

Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), all medical records and other individually identifiable health information of which we have knowledge must be kept confidential. All personal health information used by us or disclosed by us is covered by this Act regardless of whether this personal health information is in electronic, oral or paper form. Several new rights are granted to patients under this Act, allowing control over how your personal health information is used, how you can access it, and in some cases amend it.

We are required by law to maintain the privacy of your personal health information and to provide you with notice of our legal duties and privacy practices with respect to your personal health information.

We may be assessed a penalty for any misuse or unauthorized disclosures of your personal health information as regulated by HIPAA.

This Notice of Privacy Practices is effective on April 14, 2003.

We are bound to abide by the terms of this notice and reserve the right to make revisions to this policy. Should revisions be made, you will be notified in writing, and a copy of the revised policy will be made available at your request.

You will be asked to sign a consent form authorizing us to use and disclose your personal health information only for the following purposes, as defined under the Act:

- Treatment means the provision, coordination, or management of health care and related services by one or more healthcare providers, including the coordination or management of health care by a healthcare provider with a third party; consultation between healthcare providers relating to a patient for health care from one provider to another. An example of this would be a dentist referral to an orthodontist.
- Payment means obtaining reimbursement for the provision of health care; determinations of eligibility or coverage; billing; claims management; collection activities; justification of charges; and disclosure to consumer reporting agencies; protected health information relating to the collection of reimbursements (only certain information may be disclosed). An example of this would be submitting your bill for health care services to your insurance company.
- Health care operations are any activity related to covered functions in which we participate in the function of our offices, such as conducting quality assessment activities; protocol development; case management and care coordination; auditing functions; business management and general administrative activities, including implementation of this regulation; customer service evaluations; resolution of grievances; fundraising; and marketing for which an authorization is not required. An example of this would be evaluation of customer service given to our patients.

We may, without prior consent use or disclose your personal health information to carry out treatment, payment or health care operations:

- Directly to you at your request;
- In an emergency treatment situation, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment, if we are required by law to treat you and attempts to obtain consent are unsuccessful, or if we attempt to obtain consent but are unable, due to barriers of communication, but we determine in our professional opinion that treatment is clearly inferred from the circumstances;
- Pursuant to and in compliance with an authorization signed by you; and
- Provided that you are informed in advance of the use and disclosure and have the opportunity to agree to or prohibit or restrict the use or disclosure. This may be an oral agreement between us and may include a directory maintained at our facility containing specific information allowed by this Act.

We may de-identify your personal health information by using codes or removing all individually identifiable health information.

All other uses and disclosures will be made only upon securing a written authorization form signed by you. You have the right to revoke this authorization, at any time, upon written notice and we will abide by that request. However, exception would be any actions already taken, relying on your authorization, prior to revocation notice.

We may contact you (by telephone, through voicemail messages, email or with postcards or letters) to provide appointment reminders, or to inform you about treatment alternatives or other health related benefits or services that may be of interest to you.

Under HIPAA, you have the following rights with respect to your protected health information:

- You have the right to request restrictions on certain uses and disclosures of protected health information, including restrictions placed upon disclosure to family members, close personal friends, or any other person you may identify. We are, however, not required to agree with a requested restriction;
- You have the right to receive confidential communications of your protected health information, either directly from us or by alternative means or from alternative locations;
- You have the right to inspect and copy your protected health information;
- You have the right to amend protected health information; however, this request may be denied under certain circumstances;
- You have the right to receive an accounting of disclosures of your protected health information made by us in the six years prior to the date of the accounting request; and
- You have the right to obtain a paper copy of this notice from us, even if you have already agreed to receive the notice electronically.

If you feel your privacy rights or the provisions of this notice of privacy policies has been violated, you have the right to file a formal written complaint.