Elite Endodontics

2101 Pat Booker Rd. Ste 120 Universal City, TX 78148 (O) 210-599-9900 (F) 210-599-9504 www.endoelite.com

PATIENT NAME: _____

DATE OF BIRTH: _____ SS#: _____

CELL # _____ HOME #_____

EMAIL: _____ WORK #: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

GUARDIAN INFO (IF PATIENT IS A MINOR)

NAME: _____ DATE OF BIRTH: _____

FULL ADDRESS: _____

RELATION: _____

IN CASE OF AN EMERGENCY CONTACT:

NAME: _____ PHONE # _____

Your health and that of our staff and other patients is our top priority. For this reason, masks are required in our office and we will continue to follow all CDC guidelines regarding Coronavirus and its variants until further notice.

COVID VACCINE (Please circle one): YES OR NO

MEDICAL/HEALTH HISTORY INFORMATION:

ARE YOU CURRENTLY UNDER DOCTOR CARE: YES OR NO

IF YES, PLEASE EXPLAIN:

_____

_____

DOCTOR NAME: _____ PHONE #: _____

DO YOU HAVE A MEDICAL CONDITION THAT REQUIRES YOU TO BE PREMEDICATED WITH ANTIBIOTICS FOR DENTAL TREATMENT? (ex: heart condition/artificial joint)

Please circle one: YES OR NO

ALLERGIES (CHECK ALL THAT APPLY)

- ☐ NONE
- ☐ PENICILLIN
- ☐ LATEX
- ☐ SULFA
- ☐ ASPIRIN
- ☐ TYLENOL
- ☐ CODEINE
- ☐ NARCOTICS
- ☐ VALIUM
- ☐ NITROUS
- ☐ BLEACH
- ☐ IODINE
- ☐ OTHER (PLEASE LIST):

MEDICATIONS (PLEASE LIST ALL CURRENT MEDICATIONS):

Medication:	Reason for use:	Dosage:

MEDICAL CONDITIONS:

- ☐ HIGH BLOOD PRESSURE
- ☐ DIABETES
- ☐ CHOLESTEROL
- ☐ THYROID/HORMONAL
- ☐ RHEUMATIC FEVER
- ☐ SHORTNESS OF BREATH
- ☐ CHEST PAIN
- ☐ PACEMAKER, IF YES, IMPLANTABLE DEFIBRILLATOR?
- ☐ HEART DISEASE
- ☐ IRREGULAR HEARTBEAT
- ☐ HEART MURMUR/DEFECT
- ☐ HEART ATTACK, IF SO WHEN? _____
- ☐ ARTIFICIAL HEART VALVE
- ☐ ULCERS/DIGESTIVE
- ☐ KIDNEY DISEASE
- ☐ RESPIRATORY/ASTHMA
- ☐ SEASONAL ALLERGIES
- ☐ SINUS PROBLEMS
- ☐ PROSTHETIC IMPLANT
- ☐ JOINT REPLACEMENT
- ☐ BACK OR NECK PAIN
- ☐ ARTHRITIS
- ☐ FAINTING SPELLS, SEIZURES, OR EPILEPSY
- ☐ MENTAL/NEURAL
- ☐ STROKE, IF SO WHEN?
- ☐ LIVER DISEASE
- ☐ TUBERCULOSIS
- ☐ CANCER/TUMOR, IF SO WHEN? _____
- ☐ RADIATION/CHEMO, IF SO WHEN? _____
- ☐ HYPOGLYCEMIA
- ☐ TRANSPLANT, IF SO WHEN? _____
- ☐ ANEMIA/BLEEDING
- ☐ AIDS/HIV
- ☐ HERPES
- ☐ HEPATITIS
- ☐ ALCOHOLISM/ADDICTION
- ☐ PSYCHIATRIC CARE
- ☐ IMMUNOCOMPROMISED
- ☐ SMOKE
- ☐ SWELLING
- ☐ MIGRAINE/SEVERE HEADACHES
- ☐ GLAUCOMA/VISUAL
- ☐ NEOPLASMS
- ☐ TMD
- ☐ PREGNANT
- ☐ NURSING

SIGNATURE: _____ DATE: _____

HIPAA:

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 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 use and/or disclose health information about you for treatment, payment and healthcare operations. For example, **we may disclose your health information to a physician or other healthcare provider providing treatment to you. We may use and disclose your health information to obtain payment for services we provide to you.**

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 disclose it to anyone for any purpose. If you give us an authorization, you make revoke in writing at any time. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

Family/Friends: We must disclose your health information to you, as described in the patient's 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, only if you agree that we may do so.

Please list family/friend you wish to authorize at this time here:

Name: _____ Relation: _____

Healthcare Providers: 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, or 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 not use your health information for marketing communications without your written consent.

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

SIGNATURE: _____DATE: _____

FINANCIAL AGREEMENT:

Thank you for choosing **ELITE ENDODONTICS** as your specialty dental care provider. We are committed to your successful treatment and outcome. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

YOUR INSURANCE

We may accept assignment from your insurance benefits. However**, the balance is ultimately your responsibility, whether your insurance pays or not.** Your insurance policy is between you and your insurance company. If your insurance has not paid its entire estimated portion in 60 days, you are responsible for the remaining balance and have 10 days to remit payment to this office. Per insurance, "coverage is not a guarantee of benefits" therefore, when we give a financial treatment plan for recommended treatment, it is ONLY an estimate and you may still have a balance after insurance processes your claim.

****Your estimated patient portion (co-pay) and your deductible are due at the time of service. ****

If a balance remains on an account for more than 90 days without payment being made either partially or in full, the account will then be turned over to a collection agency and a minimum of 40% in collection fees may be added to the balance on the account. In addition to collection fees accounts that have not received payment within 90 days may also be subject to interest fees. Once accounts have been sent to collections all correspondence will need to be handled through their office.

In addition, your insurance company may pay based on fees considered "Usual and Customary" that differ from ours. Our practice is committed to providing the best treatment possible for our patients we charge what is usual and customary to our practice. You are responsible for payment in full regardless of your insurance company's arbitrary determination of "usual and customary" fees.

CANCELLATION POLICY

A 24-hour notice is required to change a scheduled appointment.

A $100.00 fee will be applied for all appointments cancelled or failed without notice.

We believe the dental appointment represents a shared responsibility for both the doctor and the patient. In order to have quality dental care at an affordable cost, these appointments must be kept.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy of **ELITE ENDODONTICS** and agree to the terms of the policy.

SIGNATURE: _____ DATE: _____

IMPORTANT IMAGING INFORMATION:

As a standard of care at our practice, a 3D image is taken on each tooth that is to be evaluated. This image is known as a CBCT or Cone Beam.

A CBCT scan is a specialize type of x-ray that provides more information than a conventional x-ray. Our doctors rely on this scan when looking for hidden/missed canals and/or fractures. Thus the scan is used to assist in complex root canal diagnosis and treatment planning.

CBCT images are NOT covered by most major insurance companies, therefore will not be on your Explanation of Benefits (EOB). The fee for this image, per tooth/quad is $65 and is included in the quoted consultation fee and/or same day treatment estimated fee.

By signing below, you acknowledge you have read this non-covered service form in its entirety and understand this image is not covered by your insurance.

SIGNATURE: _____ DATE: _____