endodontiCSpecialists

PATIENT INFORMATION

Comfort Menu

The team has put together a number of complimentary items to enhance your comfort while you are here for your dental care. Please give this check-list to the receptionist or ask any of the team members if you desire any of these:

☐ Fleece blanket
☐ Buckwheat pillow
☐ Ear plugs
☐ Movie goggles (for children)
☐ Mild to moderate sedation dentistry (consultation with dentist required)
Level of anxiety in a dental office 1 (least) thru 10 (most) = ________
☐ Apple iPod
☐ Hot tea at the end of your visit

A complimentary warm towel, mouth wash, and an analgesic (ex. Advil, Aleve or Tylenol) will be provided at the end of your treatment visit.

Dated: ____________
Name____
Address____
City ____________________________________State _________________Zip______________________
Home Phone______________________________Cell Phone_____________Work Phone_______________
Driver License # ___________________________Birth date______________SS#______________________
Email address____
Employer____
Business Address ___________________________City_________________ State_________ Zip__________
Whom may we thank for referring you? ____________________ ________General DDS_______________
Person to contact in case of emergency? ____________________________Phone_____________________

RESPONSIBLE PARTY (if different from above)

Name of Person Responsible for this account____
Relation to Patient____
Address____
City ____________________________________State _________________Zip______________________
Home Phone______________________________Cell Phone_____________Work Phone________________
Driver License # ___________________________Birth date______________SS#______________________
Employer_________________________________Work Phone_______________________________________
Is this person currently a patient in our office? ☐Yes ☐No

endodontic Specialists

ICOI
International Congress of Oral Implantologists

DENTAL INSURANCE INFORMATION

Name of Subscriber ____________________ Relation to Patient ____________________
Birth date ____________________ SS# ____________________
Employer ____________________
Business Address ____________________ City ____________ State _____ Zip ________
Business Phone Number ____________________

Primary Insurance Company ____________________ **Group#** ____________
Address ____________________
City ____________________ State ____________ Zip ____________
Phone ____________ ____________________

Secondary Insurance Company ____________________ **Group#** ____________
Address ____________________
City ____________________ State ____________ Zip ____________
Phone ____________ ____________________

MEDICAL INFORMATION

Physician Name ____________________ Phone ____________________
Date of last exam ____________________
Are you currently under medical treatment? □**Yes** □**No**
If yes, please explain ____________________

For the following questions answer yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Health Condition:	**Yes**	**No**	**Health Condition:**	**Yes**	**No**
Anemia or Blood Disorder?			Hepatitis, Any Form		
Arthritis, Rheumatism or other inflammatory disease?			Joint Replacement? When placed?		
Asthma			Kidney Disease		
Abnormal Bleeding from a cut?			Liver Disease (including Jaundice)		
Cancer or Tumor?			Sore/Enlarged Lymph Nodes		
Diabetes			Psychosis		
Emphysema or other Respiratory/Lung Illnesses			Previous Biopsies		
Epilepsy			Radiation or Chemotherapy Treatment		
Fainting or Dizzy Spells			Rheumatic Fever		
Glaucoma			Slow-Healing Mouth Sores		
Abnormal Heart or Previous Bacterial Endocarditis			Unintentional Weight Loss/Gain		
Heart Valve (artificial) or Heart Transplant			H.I.V. Infection/AIDS or ARC		
Congenital Heart Disease			Venereal Disease		
Heart Disease, Heart Attack, Heart Surgery			Other Conditions		
Heart Stent? When placed?			Recurrent Illnesses		
High Blood Pressure?			Women: are you pregnant?		

Are you taking any of these medications?	**Yes**	**No**	**Are you taking any of these medications?**	**Yes**	**No**
Pre-medication before dental treatment?			Tagamet® (cimetidine) or Prilosec® (omeprazole)?		
Antacids?			Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?		
Dilantin® or Tegretol®			Serzone® (nefazodone)		
Barbiturates (any)			Diflucan® (fluconazole) or Sporonox® (itraconazole)		
St. John's Wort or Kava-Kava?			Biaxin® (clarithromycin)		
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin? When did the treatment end?					
Have you ever taken any prescription drugs such as fen-phen for weight loss?					
Do you consume grapefruit juice, grapefruits or grapefruit extract?					

endodontiCSpecialists

Weight____________ Height____________ (Office use only)BMI______________
Any other medical conditions not listed: ____
Have you had any surgeries in the last year? If so please list:_____________________________
Will you be traveling by air within the next 48 hours? □Yes □No

PLEASE CHECK IF YOU HAVE ANY ALLERGIES TO THE FOLLOWING:

	Yes	**No**
Penicillin	□	□
Antibiotics	□	□
Aspirin	□	□
Tylenol	□	□
Codeine	□	□
Narcotics	□	□
Local Anesthetic	□	□
Any reaction to anesthetic	□	□
Latex	□	□
Valium/ Tranquilizer	□	□
Nitrous	□	□
Food	□	□ (If Yes Please Explain)______________________________

Any other allergies not listed:
____

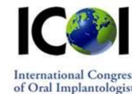
Are you or have you been ill in the last 24 hours? □ **Yes** □ **No**
**Please advise us at each visit if you are ill or have not been feeling well.

PLEASE CHECK IF YOU ARE PRESENTLY TAKING ANY TYPE OF THE FOLLOWING MEDICATIONS:

	Yes	**No**	**Name**
Antibiotics	□	□	__________
Pain Medicine	□	□	__________
Heart Medicine	□	□	__________
Aspirin	□	□	__________
Cortisone/ Steroid	□	□	__________
Blood Thinner	□	□	__________
Blood Pressure	□	□	__________
Hormone	□	□	__________
Thyroid	□	□	__________
Birth Control Pills	□	□	__________
Insulin	□	□	__________
Ulcer/ Nexium	□	□	__________
Bone Related	□	□	__________
Antidepressants	□	□	__________
Diet Pills	□	□	__________
Any PRIOR use of diet pills	□	□	__________

Other medications taken that are not listed here:
____

endodontiCSpecialists



TOBACCO, ALCOHOL & DRUGS

Do you use tobacco? No Yes

If yes please list type____

How much per day?____

For how many years?____

Do you want to quit using tobacco? No Yes

Do you consume alcohol? No Yes

If yes please list approximately how many drinks per week:______________________________

Do you use any mood altering drugs other than those previously listed? No Yes

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

____

Patient (Print Name) *Patient Signature* *Date*

____

Witness Signature *Dr. Signature*

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

____
____
____

Significant findings from questionnaire or oral interview:

____
____
____

Dental management considerations:

____
____
____

endodontiCSpecialists

INFORMED CONSENT

We are concerned not only about your dental health and endodontic treatment needs, but also about your right as a patient to make the treatment decision that you feel is best for you. Our commitment to you is to provide you with detailed and complete information about your dental needs as we diagnose them. We will share our diagnostic processes with you, and we invite and welcome all of your questions regarding our work with you.

It is important to advise you of the reasonably foreseeable risks of endodontic therapy. **The following is information you need to have in making your decision about treatment:**

- Root canal therapy is a procedure designed to retain a tooth which may otherwise require extraction. Root canal therapy has a very high degree of success. However, it is a biological procedure and results cannot be guaranteed.
- Occasionally, and despite our best efforts, a tooth that has undergone non-surgical root canal therapy may require re-treatment or root canal surgery.
- We make special efforts to preserve the crowns of teeth we treat, but despite our best efforts occasionally a porcelain crown may fracture and require a new restoration.
- Rarely, other treatment complications may occur. These include the separation of instruments inside the canals, the creations of perforations, prolonged anesthesia, or post-operative swelling. These are very rare, but possible.
- Even after root canal therapy, approximately 5% of endodontically treated teeth may eventually require extraction.
- Final restoration (crown) of the tooth that has undergone root canal therapy is essential for retention of the tooth. A final restoration should be completed **within 30 days of root canal therapy.** Final restorations are provided by your restorative dentist.

I have received, read, and understood the **Informed Consent Form**. I have had my questions addressed.

Name Date

TO ALL FEMALE PATIENTS OF CHILD BEARING AGE

Please be advised that antibiotics can reduce the effectiveness of oral contraceptives. The doctor may find it necessary to place you on antibiotics for either treatment or prevention of infection. This may be necessary for your health, but if you are taking oral contraceptives, the effectiveness can be diminished by the antibiotics. Other forms of contraception should be considered while you are taking the antibiotic. You may wish to consult your physician.

endodontiC Specialists

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 you 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 __Today__, 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 on 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 and 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 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 is 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 required by law to do so

Abuse or Neglect: We may disclose your 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 the

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. You may obtain a form to request access by using the contact information listed at the end of the Notice. We will charge you a reasonable cost-based fee for the 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 $0.50 for each page. $15.00 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 the 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 any 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 may also 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 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 the U.S. Department of Health and Human Services.

Contact Officer: Shelby L.

Clovis / Fresno
Telephone: 559-322-2054
E-Mail: info@clovisendo.com
1829 Shaw Ave, Suite 104, Clovis, Ca, 93611
7750 N. Fresno Street, Suite 105, Fresno, Ca 93720

endodontiCSpecialists

I have received, read, and understood the **Notice of Privacy Policy**. I have had my questions addressed.

____

Name Date

I ______________________, understand that any insurance coverage estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office. **In the event you need to cancel or reschedule an appointment, we require 2 business days notice to avoid a $100.00 cancellation cost.** I hereby authorize payment directly to the above named Dentist of the Insurance benefits otherwise payable to me. I authorize that charting notes and/or images may be used for educational purposes. Any insurance claim not paid in full after 60 days will become my responsibility to pay at that time. Any amount not estimated to be paid by insurance, is due the day of the office visit.

____

Patient (or responsible party) Signature: Date

FINANCIAL INTEREST DISCLOSURE

Under California law, I, Dr. Christopher Sabourin, am required to inform you that I have a financial interest in **Dental Imaging Solutions**, to which I may refer you for services. There may be other organization from which you may obtain these services, such as Pacific Dental Imaging. Should anyone decide to refer you to **Dental Imaging Solutions**, you should know that there may be alternative locations to acquire similar requested services.

____

Patient (or responsible party) Signature: Date

I have received, read, and understood the **Post-Procedure Instructions**. I have had my questions addressed. (This form will be given to you at the end of your visit and your signature will not be necessary until then.)

____

Name Date

Clovis
1829 Shaw Ave, Suite 104
Clovis, Ca 93611
559.322.2054

Fresno
7750 N Fresno Street, Suite 105
Fresno, Ca 93720
559.322.2054