Welcome
Welcome
Welcome

ORANGE MICRO ENDODONTICS

1500 E. KATELLA AVE. UNIT O
ORANGE, CALIFORNIA 92867

PATIENT INFORMATION

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. _____ Last Name _____ Nickname _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____

Street _____ City _____ State _____ Zip _____

Home Tel.(_____) _____ Cell.(_____) _____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ Medical Doctor _____ Referred By _____

Driver's Lic.# _____ Nearest relative not living with you _____ Tel.(_____) _____

Employer _____ Bus. Tel.(_____) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

Who will be responsible for your account?

(If self, skip to next section)

❑ Self ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ S.S.# _____ Birth Date _____ Age _____ Tel.(_____) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel.(_____) _____

Spouse or other guarantor information (*if different from above*)

Name _____ Relation _____ S.S.# _____ Tel.(_____) _____

Street _____ City _____ State _____ Zip _____

Employer _____ Bus. Tel.(_____) _____

INSURANCE INFORMATION

Student: ❑ Full Time ❑ Part Time ❑ Not School Name/Address _____

❑ Married ❑ Divorced ❑ Legally Separated ❑ Widow ❑ Single _____

Employed: ❑ Full Time ❑ Part Time ❑ Retired ❑ Not Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY INSURANCE COMPANY

Insurance Type: ❑ **Dental** ❑ **Medical**

Employer _____

Bus. Address _____

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Tel.(_____) _____

Group # _____ **Group Name** _____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Birth Date _____

Street _____

City, State, Zip _____

Tel.(_____) _____ S.S. # _____

I.D. # _____

SECONDARY INSURANCE COMPANY

Insurance Type: ❑ **Dental** ❑ **Medical**

Employer _____

Bus. Address _____

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____

Address _____

_____ Tel.(_____) _____

Group # _____ **Group Name** _____

Insured Party _____ Relation _____

Sex: ❑ M ❑ F Birth Date _____

Street _____

City, State, Zip _____

Tel.(_____) _____ S.S. # _____

I.D. # _____

DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Consultation ❑ Emergency Are you in pain? ❑ Yes ❑ No, For How Long? _____

Please indicate any of the following problems by checking off the corresponding box:

❑ Discomfort, clicking, or popping in jaw
❑ Red, swollen, or bleeding gums
❑ A removable dental appliance
❑ Blisters / sores in or around the mouth
❑ Prolonged bleeding from an injury, extraction
❑ Recent infections or sore throat
❑ My teeth are sensitive to: ❑ Hot ❑ Cold ❑ Sweets ❑ Biting

❑ Lost / broken filling(s)
❑ Teeth grinding / clenching
❑ Ringing in ears
❑ Broken / chipped tooth
❑ Gum disease
❑ Toothache

❑ Stained teeth
❑ Locking jaw
❑ Bad breath
❑ Burning tongue/lips
❑ Grind / clench teeth
❑ Other:

❑ Difficulty closing jaw
❑ Difficulty opening jaw
❑ Loose / shifting teeth
❑ Food caught between teeth
❑ Swelling / lumps in mouth

Last Dental exam _____ Last Dental X-rays _____ Times a day you brush? _____ Times a week you floss? _____

What type of tooth bristles do you use? ❑ Soft ❑ Medium ❑ Hard How would you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

MEDICAL HISTORY

Are you in good health? ❑ Yes ❑ No Height _____ Weight _____ Are you under the care of a physician? ❑ Yes ❑ No

Have you had any illness, operation, or been hospitalized in the past five years? ❑ Yes ❑ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N		Y	N	
❑	❑	Rheumatic fever	❑	❑	Asthma	❑	❑	Bleeding tendency	❑	❑	Low Blood Sugar
❑	❑	Mitral valve prolapse	❑	❑	Hay fever / Sinus problems	❑	❑	Jaundice / Liver Disease	❑	❑	Kidney trouble
❑	❑	Heart murmur	❑	❑	Snoring / Sleep apnea	❑	❑	Hepatitis	❑	❑	Are you on dialysis
❑	❑	High blood pressure	❑	❑	Respiratory Problems	❑	❑	HIV / AIDS	❑	❑	Arthritis / Joint disease
❑	❑	Low blood pressure	❑	❑	Tuberculosis	❑	❑	Infectious mononucleosis	❑	❑	Stomach ulcers
❑	❑	Chest pain / Angina	❑	❑	Emphysema	❑	❑	Gallbladder trouble	❑	❑	Contagious diseases
❑	❑	Heart attack(s)	❑	❑	Do you smoke	❑	❑	Fainting spells	❑	❑	Delay in healing
❑	❑	Irregular heart beat	❑	❑	Do you use chewing tobacco	❑	❑	Convulsions / Epilepsy	❑	❑	Anemia
❑	❑	Cardiac pacemaker	❑	❑	Blood transfusion	❑	❑	Stroke	❑	❑	Tumor or growth
❑	❑	Heart surgery	❑	❑	Blood disorder	❑	❑	Thyroid trouble	❑	❑	Radiation / Chemotherapy
❑	❑	Bronchitis / Chronic cough	❑	❑	Bruise easily	❑	❑	Diabetes	❑	❑	Are you on a diet
❑	❑	Chronic fatigue / Night sweat	❑	❑	A history of drug abuse	❑	❑	A history of alcohol abuse	❑	❑	Contact lenses
❑	❑	Mental health problems	❑	❑	Eye disease / Glaucoma	❑	❑	Sexually transmitted diseases	❑	❑	Immune system problems
❑	❑	Damaged heart valves	❑	❑	Abnormal bleeding	❑	❑	Swollen ankles	❑	❑	Malignant hyperthermia

MEDICATION AND ALLERGIES

Are you now taking:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Nerve pills	❑	❑	Pain killers (including aspirin)	❑	❑	Muscle relaxers	❑	❑	Stimulants
❑	❑	Have you ever taken diet pills	❑	❑	Tranquilizers	❑	❑	Insulin	❑	❑	Antidepressants
❑	❑	Blood Thinners (Coumadin, Aspirin, Advil)									

Please list any other medication you are taking (including natural, herbal, or homeopathic products):

Are you allergic to or had a reaction to:

Y	N		Y	N		Y	N		Y	N	
❑	❑	Penicillin	❑	❑	Sulfa drugs	❑	❑	Local anesthetic (numbing med)	❑	❑	Sodium pentothal
❑	❑	Valium or other tranquilizers	❑	❑	Aspirin	❑	❑	Codeine or other narcotics	❑	❑	Latex
❑	❑	Soy	❑	❑	Eggs / Yolk	❑	❑	Sulfites	❑	❑	Amoxicillin

Please list any other medication or antibiotic you are allergic to:

Please list any allergies other than drug allergies:

1-4 below for women only: *(women note: antibiotics (such as penicillin) may alter the effectiveness of birth control pills. consult your physician / gynecologist for assistance regarding additional methods of birth control.)*

1) Is there a possibility of pregnancy? ❑ Yes ❑ No **2)** Expected delivery date: _____

3) Are you nursing? ❑ Yes ❑ No **4)** Are you taking birth control pills: ❑ Yes ❑ No

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my surgeon, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient: *(Parent or Guardian if minor)* X **Reviewed by:** X **Date:** X

FEES AND PAYMENTS

We make every effort to keep down the cost of your oral surgical care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

Signature of patient: *(Parent or Guardian if minor)* X **Date:** X

Print Form

ORANGE MICRO ENDODONTICS

Endodontic Informed Consent

I _____have been advised by Dr. _____(my referring dentist) that I require root canal treatment on tooth #____.

I understand that root canal treatment is an attempt to save my tooth due to loss of vitality from infections, decay, crack or to obtain sufficient retention for restorations. The alternative to root canal treatment is extraction.
I have discussed the root canal procedure with my Endodontist and I understand that the following risks and complications may arise:

___ Root canal treatment requires anesthesia and multiple radiographs (x-rays).
___ Local anesthesia injection sometimes causes trismus (difficulty in jaw opening) or parasthesia (temporary or permanent loss of sensation).

___ Post-operative discomfort or swelling, lasting a few hours to several days, for which medication will be prescribed if deemed necessary by the Endodontist.
___ Allergic reactions to medication or anesthetics.
___ Separation of root canal instruments during treatment which may, in judgment of the Endodontist, be left in the treated root canal or require surgical procedure for removal.
___ Perforation of the root canal due to curved roots or existing conditions. This may require additional surgical treatment or extraction.
___ Premature tooth loss may result from cracks of fractures that can occur during the root canal treatment or from progressive periodontal gum disease.
___ Access through a crown or bridge (existing restorations) may result in damage to restorations, which is not the responsibility of your endodontist.
___ Treatment may be discontinued due to calcified canals, separation of root canal instruments, or fractures of root or crown.
___ Success rate of root canal treatment is approximately 95% (If failure occurs the treatment may have to be redone, surgerized, or extracted).
___ Post-surgical complications include: discomfort and pain, swelling, bruises, excessive bleeding, trismus and injury to the nerve underlying the teeth which may result in numbness or tingling of the lip, chin, gums or tongue on the operated side. This may persist for several weeks, months, or in remote instances permanently. Also, there may be exposure of the sinus in the upper teeth.
___ The crown of the tooth may darken eventually and/or become brittle due to loss of vitality. We recommend placement of the crown or any other proper restoration determined by your referring dentist as soon as possible after the root canal treatment.

I understand tat at any time during treatment, common medications may be prescribed that may have side effects such as nausea and diarrhea. If any adverse side effects such as itching, rash, or hives occur, I am to stop the medication and call my doctor.

I understand that failure to continue with initiated treatment may result in the eventual loss of the tooth through decay, fracture, or extraction. If this occurs I cannot hold the Endodontist who initiated the treatment responsible.

I understand that doing root canal therapy through crowns may hide existing decay or cracks, that are not visible to the Endodontist and therefore I cannot hold them responsible for missing them.

I understand that after my root canal treatment is completed I should continue my treatment by placing a proper restoration on the tooth.

The undersigned certifies that he/she has read and is willing to comply with the foregoing and is the patient, the parent with authority to give consent or guardian of the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Patient_____ Date_____

Parent/Guardian_____ Date_____

ORANGE MICRO ENDODONTICS

Notice of Privacy Practices for Protected Health Information

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!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:
A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:
We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:
We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights
The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Obtain a paper copy of this Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact , in person or in writing, during normal hours. will provide you with assistance on the steps to take to exercise your rights.

You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

Our Responsibilities

The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address and e-mail address is

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family
Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)
We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health
As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions
If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses
Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Website
If we maintain a website that provides information about our entity, this Notice will be on the website.

Effective Date: