Chart#:_________

Fife and Steffen Endodontics

David C. Fife, D.D.S.
Joshua J. Steffen, D.D.S.

Welcome to our office. We appreciate the confidence that your dentist has placed in us by referring you for endodontic treatment. Our goal is to provide you with the highest quality endodontic therapy in a painless and professional manner. Please complete this form. *Thank you.*

Date:____________

Name:___________________________ Date of birth:____________ SS#:__________________________

Address:___________________________________ City:___________________ State:_______ Zip:________

Home phone:_____________________ Cell phone:_____________________ work phone:_______________

Occupation:________________________ Employer:_________________________

Person to contact in case of emergency:___________________________ phone:_________________

Referring dentist:_________________________ Physician's name:____________________

Do you have dental insurance? Y N Do you have a secondary dental insurance policy? Y N

MEDICAL HISTORY

Have you ever had any of the following? (*please circle*)

Y N Heart Condition	Y N Asthma	Y N High Blood Pressure	Y N Respiratory Problems
Y N Heart Murmur	Y N Diabetes	Y N Angina Pectoris	Y N Thyroid Problems
Y N Mitral Valve Prolapse	Y N Emphysema	Y N Bleeding Disorders	Y N Arthritis
Y N Artificial Heart Valve	Y N Hepatitis	Y N Cancer/Chemo/Radiation	Y N Sinusitis
Y N Rheumatic Fever	Y N HIV / AIDS	Y N Epilepsy / Seizures	Y N Ulcers
Y N Joint Prosthesis	Y N Tuberculosis	Y N Fainting / Dizzy Spells	Y N Drug / Alcohol Problem
Y N Cardiac Pacemaker	Y N TMJ problems	Y N Liver Problems	Y N Latex Allergy
Y N Stroke	Y N Jaw locking	Y N Kidney Problems	Y N Immune System Problem

Are you pregnant or nursing?______ Have you had problems with past dental treatment?_________________

List all current medications:____

Allergies to medications?_____________________________ Do you have any disease, problem, or condition not listed above that we should know about?____

Have you ever been instructed by a dentist or physician to take antibiotics prior to dental treatment?_____________

CONSENT FOR TREATMENT

I have completed this form fully and completely. I grant permission to the doctor and staff to perform the examination and if needed, treatment. I understand that endodontics is successful approximately 90-95% of the time. As with any branch of medicine or dentistry, no guarantee of treatment success can be given or implied. Cases started by another dentist may have a lower success rate. If a surgical procedure is necessary, an additional fee will be charged. It may be necessary to alter the tooth structure or crown or bridgework to perform this procedure. Possible complications of treatment include: a. procedural difficulties due to narrow, calcified canals, b. instrument failure (fracture), c. fracture of crown/porcelain/filling, d. persistent numbness following surgical procedures, e. continued swelling and/or discomfort. I understand that endodontics is an elective procedure. The alternative to this procedure is removal of the tooth. I understand that a surgical procedure, or removal of the tooth, is necessary in approximately 5-10% of the cases treated. When endodontic therapy is completed, I understand that my tooth will require a permanent restoration, which will be either a filling or a crown. My general dentist will render this service which is mandatory for the preservation of the tooth. I understand that even though I may have some type of insurance coverage, I am responsible for payment of services.

Patient/Guardian's Signature**:**_______________________________________ **Date**____________________

(OVER)

office use only:
: Ins. Sent

FINANCIAL POLICY

We believe that patients appreciate being informed of our payment policy prior to treatment. Please feel free to discuss the treatment or fee at any time. In our office, payment is due as services are rendered. Approximately 90% of the endodontic treatment we perform is completed in a single visit. If treatment requires additional visits, payment in full is expected on the first visit. You will be informed of the total fee prior to beginning any treatment.

As a courtesy to you, primary insurance forms will be filed for you, and we will strive to help you receive the maximum reimbursement from your insurance company. However, the filing of an insurance claim is not a guarantee of payment. The ultimate responsibility for payment is with the patient. YOU ARE RESPONSIBLE FOR KNOWING YOUR INSURANCE BENEFITS. Our office allows 45 days for reimbursement. After 45 days any remaining balance is due regardless of the status of the insurance claim. A bill will be mailed and you will have 14 days to pay the balance in full or be subject to a $25.00 late fee per month. If your account is sent to collections you will be charged a collections fee (as much as 50% of the balance due). Insurance companies frequently reimburse at a lower rate than we estimate. When this occurs, you may be required to pay an additional "after insurance" balance. A $25.00 fee will be added for returned checks.

I have read and understand the financial policy of Fife and Steffen Endodontics.

Signature of patient or responsible party Date

Notice of Privacy Practices

Federal Law requires that we explain our policy to secure your private personal and health information. You will be offered a form that describes how health information about you may be used, and how we assure the security of your personal information. Please review it. You may receive a copy of our policy if you desire one. The privacy of your health information is important to us.

I acknowledge that I have reviewed the notice of privacy practices from Fife and Steffen Endodontics, and I authorize the use of my health information to carry out treatment, payment activities, and health care operations

Signature of patient or responsible party Date

Thank you for filling out these forms. You are a welcomed guest in our office, and our goal is provide you with the best treatment available. If we can be of further assistance in any way, please feel free to ask. Thank you.