MICHANOWICZ ENDODONTICS

Patient ____

Address ____

____

Phone # __________________ SSN ________________

Cell # ____________________ Work_________________

Birth date ___/___/___ Age: ___ Sex: __M __ F

Employer ____

Emergency Contact Name and Phone #

____

Check: If you have any of these conditions, and need antibiotics before dental treatment.

____MITRAL VALVE PROLAPSE
____ARTIFICAL VALVE/STENTS
____HIP/KNEE/JOINT REPLACMENT

DENTAL INSURANCE CO.__________________________

Subscriber_______________________________________

Subscriber's birth date ____/____/____

SSN ______________________________

Employer _______________________________________

Group # ___________________

SECONDARY INS. CO.______________________________

Subscriber_______________________________________

Subscriber's birth date ____/____/____

SSN ____

Employer _______________________________________

Group # ___________________

I authorize the release of any dental information necessary to process my claims, and agree to pay any portion of what my insurance does not cover. **All arrangements must be made in advance.**

Signature: _________________________Date:_________

Family Dentist Name _____________________________Who referred you to our office?_______________________

Are you pregnant? ______ How many weeks/months? _______ Are you taking oral contraceptives? __yes __no

CIRCLE MEDICATIONS THAT YOU ARE ALLERGIC OR SENSITIVE TOO:

Penicillin Sulfa Keflex Erythromycin Tetracycline Local Anesthetic Codeine Narcotics Tylenol

Aspirin Latex Nitrous Oxide Valium Ibuprofen Foods Other____

PLEASE LIST ALL YOUR MEDICATIONS: ____

____

CHECK IF YOU HAVE OR HAD ANY OF THE FOLLOWING:

__Aids (HIV)
__Allergies/Sinus
__Anemia/Sickle Cell
__Arthritis
__Artificial Joint/Valve
__Asthma
__Blood Disease Disorder
__Blood Transfusion
__Bruise easily
__Cancer
__Chemotherapy/Rad
__Cortisone
__Diabetes
__Drug Addiction
__Emphysema
__Epilepsy/Seizures
__Frequent Cough
__Glaucoma
__Heart Conditions
__Heart Murmur
__Hemophilia
__Hepatitis
__Herpes
__High Blood Pressure
__Hypoglycemia
__Kidney Trouble
__Low Blood Pressure
__Lung Disease
__MS
__MVP
__Nervousness
__Organ Transplant
__Pain in Jaw Joints
__Psychiatric Care
__Recent Weight Loss
__Rheumatic Fever
__Shortness of Breath
__Stroke
__Swelling of feet/hands
__Thyroid Disease
__Tuberculosis
__Ulcers
__Venereal Disease
__Other_______________

(TURN OVER)

DESCRIPTION OF DENTAL PAIN (Check all that APPLY TODAY)

____Bubble on the gum
___ Change in altitude causes pain
___ Cold liquids/foods cause pain
____Constant pain
___ Dull ache
____Ear pain
____Gums are sore/bleeding
____Hot liquids/foods cause pain
____Pain comes & goes
____Previous root canal
____Sharp/shooting pain
____Sweets cause pain
____Tooth feels loose
____Tooth keeps you awake
____Tooth sore to touch or chew
____Throbbing pain
____Jaw pain
____Symptom Free

HIPAA PRIVACY POLICY

Persons Involved in Care: We may disclose your health information to a family member, or any person responsible for your care. In the event of an emergency, we will disclose information based on our professional judgment. We will use our judgment and experience to make reasonable inferences of your best interest in allowing a person to pick up prescriptions, medical supplies, x-rays, or other health information.

Required by Law: We may disclose information required by law; such to the extent necessary to avert a serious health or safety threat to you or others. We may disclose information to military and federal officials required for intelligence, and other national security activities.

Appointment Reminders: We may disclose your health information to provide you with an appointment reminder such as voicemail and letters.

Patient Rights: You have the right to get copies of your health information; this request must be in writing.
Disclosure Accounting: You have the right to receive a list of instances in which we disclosed your health information.
Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of you health information. We do not have to comply.
Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means/locations. This request must be in writing.
Amendment: You have the right to request that we amend your health information, this request and explanation must be in writing. We may deny the request.

We support your privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us/U.S. Department of Health/Services. We are required by law to maintain the privacy of, and provide you with this written notice of our legal duties and privacy practices.

Contact Officer: Angel Michanowicz **(814) 696-1800 Fax (814) 696-5950**

Signature below is only acknowledgement that you received this Notice of our Privacy Practices:

PRINT____SIGNATURE_____________________________________DATE: ____________

ENDODONTIC CONSENT AND INFORMATION

I, the undersigned, certify that the information on both pages are correct and accurate.
I understand that root canal therapy is a procedure to attempt to save a tooth which may otherwise require extraction. Root canal therapy has a very high degree of clinical success, healing is influenced by many factors. On rare occasions, a tooth which has root canal treatment may require retreatment, surgical correction, or even extraction.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY: The risks include the possibility of instruments broken within the root canals; perforations (extra openings) of the crown or root of the tooth; damage to bridges, existing fillings, crowns or porcelain veneers, loss of tooth structure in gaining access to canals, and cracked teeth. During treatment complications may be discovered which make treatment impossible, or which may require dental surgery. These complications may include the following: blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), splits or fracture of teeth, and perforation of the pulp chamber and root canal system. I UNDERSTAND THAT I AM LEAVING THIS OFFICE WITH A TEMPORARY FILLING, AND THE PERMANENT RESTORATION (FILLING, CROWN, ONLAY ETC WILL BE COMPLETED BY MY GENREAL DENTIST.

Signature of Patient/Parent___________________________ Date________ Dr. Michanowicz_____________________