TIME 03:52 PM

DATE 10/22/201

PATIENT REGISTRATION

ID: ____________ Chart ID: ____________

First Name: ____________ Last Name: ____________ Middle Initial: ____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: ____________

Responsible Party (if someone other than the patient)

First Name: ____________ Last Name: ____________ Middle Initial: ____

Address: ____________ Address 2: ____________

City, State, Zip: ____________ Pager: ____________

Home Phone: ____________ Work Phone: ____________ Ext: ______ Cellular: ____________

Birth Date: ____________ Soc Sec: ____________ Drivers Lic: ____________

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: ____________ Address 2: ____________

City: ____________ State / Zip: ____________ Pager: ____________

Home Phone: ____________ Work Phone: ____________ Ext: ______ Cellular: ____________

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: ____________ Age: ______ Soc Sec: ____________ Drivers Lic: ____________

E-mail: ____________ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: ____________ Pref. Dentist: ____________

Employer ID: ____________ Pref. Pharmacy: ____________

Carrier ID: ____________ Pref. Hyg: ____________

Section 3

Primary Insurance Information

Name of Insured: ____________ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: ____________ Insured Birth Date: ____________

Employer: ____________ Ins. Company: ____________

Address: ____________ Address: ____________

Address 2: ____________ Address 2: ____________

City, State, Zip: ____________ City, State, Zip: ____________

Rem. Benefits: ____________ Rem. Deduct: ____________

Secondary Insurance Information

Name of Insured: ____________ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: ____________ Insured Birth Date: ____________

Employer: ____________ Ins. Company: ____________

Address: ____________ Address: ____________

Address 2: ____________ Address 2: ____________

City, State, Zip: ____________ City, State, Zip: ____________

Rem. Benefits: ____________ Rem. Deduct: ____________

Time 3:53 PM

Paul Satchell DDS MS PA

Eaglesoft Medical History

Date 10/22/2014

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	◯ Yes ◯ No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:__________

PAUL SATCHELL DDS MS PA

Endodontists
the root canal specialists

PRIVACY PRACTICES AND HIPAA EMAIL CONSENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance and Portability Act of 1996 (HIPAA). I also understand that by signing this consent that I authorize this office to use and disclose my protected health information in order to carry out: Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment), Obtaining payment from third party payers (e.g. my insurance company), Operations on a day-to-day basis at this office.

I have also been informed of, and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at anytime to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or, disclosure that occurred prior to the date I revoke this consent is not affected.

____

Patient (or guardian) signature   Date

____

Witness (professional staff member)   Date

- HIPAA stands for the Health Insurance Portability and Accountability Act
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- Information stored on our computers is encrypted
- Most popular email services (ex. Hotmail, Gmail, Yahoo) do not utilize encrypted email
- When we send you (or a provider) an email or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you (or the provider), someone may be able to access your email account and read it.
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA
- The information is available in a pdf (page 5634) on the US Department of Health and Human Services website.
- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient (or a provider) personal medical information via unencrypted email

☐ <u>OPTION 1- DO NOT ALLOW UNENCRYPTED EMAIL</u>
I do not wish to receive or have my personal health information sent via email.

☐ <u>OPTION 2- ALLOW UNENCRYPTED EMAIL</u>
I understand the risks of unencrypted email and do herby give permission to Paul Satchell DDS MS PA to send me (or a provider) personal health information via unencrypted email.

_______________________   _______________________

Print name   Email address

____

Patient (or guardian) signature   Date

CONSENT FOR ENDODONTIC (ROOT CANAL) TREATMENT

Patient's Name ________________________________ Date ____________

Please initial each paragraph after reading. If you have any questions, please ask your doctor BEFORE initialing.

You have the right to be informed about your diagnosis and planned treatment so that you can decide whether to have a procedure or not after knowing the risks and benefits.

____ 1. My doctor has explained the following information about root canal therapy:

Root canal treatment is the procedure of cleaning diseased or infected tissue from inside the tooth followed by placement of a seal in the root canal. Using a local anesthetic, there is little or no discomfort during the procedure. Root canal therapy allows the tooth to remain in the mouth and contributes to sound, healthy and functional dentition for many years, if not a lifetime. The practice of endodontics also includes such procedures as bleaching, inducing closure of immature diseased root, treatment of traumatic injuries and the fabrication of posts and buildups under crowns.

My diagnosis/planned treatment is: ____

______2. My doctor has explained that there are alternatives to root canal treatment that include:

A. Extraction of the tooth. If the tooth is removed and not replaced, the empty space will create problems in tooth alignment because of shifting of adjacent teeth. This may result in periodontal (gum) disease and more teeth could be lost as a consequence. The missing tooth may be replaced by a bridge or partial denture, but the cost of this treatment is more expensive than root canal treatment and involves dental work on adjacent teeth.
B. Implant placement.
C. No treatment. This often results in persistent or recurrent pain and infection in the affected tooth

_____ 3. I understand that there are risks associated with the proposed treatment including:

A. Possibility of perforation of the tooth or tooth root
B. Damage to existing restorations (fillings)
C. A split or fractured tooth
D. Separation of a portion of an instrument that cannot be removed from within the tooth
E. Pain
F. Swelling
G. Infection
H. Injury to the nerve that gives feeling to the face that could result in pain or a numb feeling in my chin, lip, cheek, gums, teeth or tongue. It is also possible to lose my sense of taste. This might last for weeks or months. It can be permanent, but this rarely happens.
I. Other: ______________________________

I have not been given any guarantee or warranty of success for this treatment, and understand that each patient is different, making it impossible to predict results exactly. Although improvement is expected, I also understand that my condition may be the same, better or worse after treatment and that ongoing care may be necessary.

I have provided a complete and accurate statement of my medical and social history. I understand that after root canal treatment, it is usually wise to have the tooth properly restored within a reasonably short time. Depending upon the situation, certain other post-treatment precautions or special instructions must be followed (such instructions will be given separately by the doctor or staff).

CONSENT

I understand that my doctor can't promise that everything will be perfect. I understand that the treatment listed above and other forms of treatment or no treatment at all are choices I have. I have read and understand the above and give my consent to treatment. I have given a complete and truthful medical history, including all medicines, drug use, pregnancy, etc. I certify that I speak, read and write English. All of my questions have been answered before signing this form.

____

Patient's (or Legal Guardian's) Signature Date

____

Doctor's Signature Date

____

Witness' Signature Date