REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle:

☐ Mr. ☐ Miss
☐ Mrs. ☐ Ms.

Marital status (circle one)
Single / Mar / Div / Sep / Wid

Birth date: Age: Sex: (circle one) M F

Street address: Social Security no.: Phone no.: ( )

P.O. box: City: State: ZIP Code:

Occupation: Employer: Employer phone no.: ( )

Family Physician: General Dentist:

Phone # : Phone # :

DENTAL INSURANCE INFORMATION

Primary Dental Insurance name :

Subscriber's name: Birth date: Address(if different from above) S.S.# / ID #

Group #: Insurance Co. Phone #

Policy #:

Occupation: Employer: Employer address: Employer phone no.: ( )

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable): Subscriber's name: S.S. # / ID Group #:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative Relationship to patient: Home phone no.: ( ) Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature ***Date***

Patient Name____ **Birth date** _____________

Medical History

Have you ever had any of the following?

	Heart attack or bypass	yes	no
______	Heart Valve disease	yes	no
______	Mitral Valve Prolapse	yes	no
______	Rheumatic fever	yes	no
______	High or low blood pressure	yes	no
______	Blood disease	yes	no
______	Bleeding problem (hemophilia)	yes	no
______	AIDS or HIV infection	yes	no
______	Diabetes	yes	no
______	Respiratory Disease (TB ,Asthma, Emphysema)	yes	no
______	Liver Disease	yes	no
______	Kidney disease	yes	no
______	Stomach or intestinal issues	yes	no
______	Venereal disease	yes	no
______	Epilepsy	yes	no
______	Hip or joint replacement	yes	no
______	Substance abuse problem	yes	no
______	Cancer or treatment	yes	no
______	Allergic to any medications?	yes	no

If yes, please list them____

____

Have you ever taken any drugs for osteoporosis? yes no

If yes, please list____

Are you being treated for any medical problems? yes no

If yes, please explain____

____

Please list any medication you are taking_________________________________

____

WOMEN

Are you pregnant or nursing? yes no

Dental History

Do you have problems keeping your mouth open	yes	no
Do you clench or grind your teeth	yes	no
Do you have gum disease	yes	no
Have you experienced any growth or sore spots in your mouth	yes	no

CERTIFICATION:

I certify that the answers given are correct to the best of my knowledge.

*Signature*____ Date_____________

3D CBCT Consent Form

General Information

A CBCT scan, also known as Cone Beam Computer Tomography, is an x-ray technique that produces a three-dimensional image of the teeth and jaw bone. This provides visualization in multiple cross-sectional views rather than just one point of view allowed by conventional x-rays. 3D CBCT scans can be helpful in diagnoses and treatment planning when information from conventional x-rays is limited.

Risks

CBCT scans, like conventional x-rays, expose you to radiation. The total dosage is approximately the same as 1-5 days of U.S. background radiation exposure, depending on the region of the scan.

A CBCT scan may or may not reveal coincidental medical findings unrelated to your dental condition. Scans will be reviewed by Dr. Palte and/or your prescribing dentist. If indicated, Dr. Palte and/or your prescribing dentist may elect to have the scan additionally reviewed by an oral radiologist. There may be extra cost involved with this additional interpretation beyond the fee for the scan itself.

CBCT scans are typically NOT recommended for pregnant women. Please inform us if you are pregnant or may be pregnant. Check below where appropriate.

☐ Definitely not pregnant ☐ I am pregnant or may be pregnant

Please inform us if you have a latex allergy so proper precautions can be taken.

☐ I have a Latex Allergy

If you are coming from another dentist for the sole purpose of taking a 3D CBCT scan, it is your responsibility to continue dental care with your prescribing dentist and Dr. Palte will not be taking part in treatment planning or treatment of your dental needs.

Initial ________ **I have read and understand everything explained on this form above**

______________________	______________________	______________
Printed Name	Signature	Date
______________________	______________________	______________
Date of Birth	Patient's Dentist	Account #

Palte Endodontics
306 W Washington Ave, Jackson, MI 49201
Phone: 517-787-4122 Fax: 517-787-5075
www.palteendo.com

ENDODONTIC INFORMATION AND CONSENT FORM

Informed consent is a procedure designed to communicate to all patients reasonable foreseeable consequences that may or may not occur during treatment. This disclosure is not meant to frighten or alarm you: it is simply an effort to make you better informed so that you may give or withhold your consent to the procedure.

Endodontic therapy is a treatment performed in order to save a tooth which otherwise might need to be removed. It consists of anesthetizing the tooth or area, making an opening through the top or inside of the tooth and removing the pulp tissue for the tooth and roots. The empty canal is then filled with an inert material and the opening in the top is sealed with a **TEMPORARY** restoration. That completes the root canal treatment. The **TEMPORARY** restoration needs to be replaced ***by YOUR GENERAL DENTIST*** with a filling or a crown.

The risks include but are not limited to complications resulting from the use of medications as well as from the procedure itself. The complications include swelling, pain, bleeding, infection, numbness, transient paresthesia with an infrequent possibility of permanent paresthesia, temporomandibular joint difficulty; allergic reaction, nausea, vomiting, sinus perforation and delayed healing. During the procedure instruments may become separated within the root canal, perforation of the crown or root may occur, teeth may crack, porcelain veneers may fracture, and damage can occur to the bridges, existing fillings, or crowns. In addition complications may be discovered which make treatment impossible. This is most often due to blocked canals from natural causes or prior treatment on the tooth.

Root canal therapy has a high degree of success however it cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery or even extraction.

I understand the risks involved as explained above. I consent to the performing of root canal treatment which was decided upon to be necessary or advisable in the opinion of the doctor. I also understand that upon the completion of treatment I shall return to my **GENERAL DENTIST** for a more permanent restoration of the involved tooth.

______________________________________ ______________________

Patient signature (parent or legal guardian if minor) **Date**

Doctors Signature____

Palte Endodontics

Acknowledgement of Receipt of Notice of Privacy Practices

PATIENT ACKNOWLEDGEMENT

Please sign this form below to acknowledge that you have seen a copy of the Privacy Practices.

(Please print your name here) (Date)

(Signature)

For Office Use Only

Patient refused to sign

The following circumstances prohibited the patient from signing the Acknowledgement.

An emergency situation prevented the patient from signing the Acknowledgement.

FINANCIAL POLICY

Welcome to our office. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. All patients must complete our Patient Information and Medical History. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

*** PAYMENT IS DUE AT THE TIME OF SERVICE***

OPTIONS OF PAYMENT = CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER OR CARE CREDIT

*** BALANCES ARE SUBJECT TO A MONTHLY FINANCE CHARGE OF 1.5% OR 18% ANNUALLY***

MINOR PATIENTS

Children under the age of 18yrs old will not be seen if a parent or legal guardian is not present. The adult signing the consent policies, regardless of divorce decree, or any other agreement is responsible for full payment.

INSURANCE POLICY

It is important that all of your insurance information is completed and correct on the Patient Information Form. Our practice is committed to provide the best treatment for our patients and our charges reflect the quality and expertise of our specialty. Our office does not participate with any insurance programs, however as a courtesy to you we will submit the insurance claim for proper reimbursement.

Your insurance policy is a contract between you and your insurance company.

***You are responsible for all charges whether your insurance company pays or not. ***

Unless canceled, at least 24hr in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

I have read and understand Dr. Eric Palte D.D.S., M.S. Financial Policy. I agree all charges are my responsibility as explained in this policy.

______________________________ ______________________

Signature of Patient or Responsible Party Date