ADA®

Patient Screening Form

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐Yes ☐ No	☐Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐Yes ☐ No	☐Yes ☐ No
Do you/they have a cough?	☐Yes ☐ No	☐Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐Yes ☐ No	☐Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐Yes ☐ No	☐Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐Yes ☐ No	☐Yes ☐ No
Is your/their age over 60?	☐Yes ☐ No	☐Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐Yes ☐ No	☐Yes ☐ No
Have you/they traveled in the past 14 days?	☐Yes ☐ No	☐Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

Huntington Beach Microscopic
Endodontics & Microsurgery

18377 Beach Blvd
Suite 106 Huntington Beach,
CA 92648
Phone : 7148478600 and 7148478664

CONFIDENTIAL

Date:____________________

PATIENT INFORMATION

Have you or a family member been a previous patient in our office? Yes [] No []

Name: ____ Female ☐ Male ☐
First MI LAST

Date of Birth:____________ Social Security Number:________________ Driver's License #:________________

Address:______________________________City: __________________State:________Zip:________

Home Phone: ______________________ Work:______________________ Cell:________________

Employer:______________________ Employer's Address:________________________________

Name of Spouse: ______________________ Spouse's Social Security #:________________________

Name of School (if student):__________________ Phone #:______________ State:________ Zip:________

In case of Emergency, notify:__________________ Phone #:__________________ Relationship: ________

Who referred you to our office?: ______________________ Patient's General Dentist: ________________

DENTAL INSURANCE INFORMATION

***Primary*:**

Insurance Company: ________________________ Group #:______________ Union/Local #:________________

Name of Insured: ______________________ Relationship: ______ Employer:______________

Date of Birth: __________________ Social Security Number:________________

***Secondary*:**

Insurance Company: ________________________ Group #:______________ Union/Local #:________________

Name of Insured: ______________________ Relationship: ______ Employer:______________

Date of Birth: __________________ Social Security Number:________________

FINANCIAL INFORMATION

If same as above, please check the box and sign below: ☐

All accounts are due and payable at time service is rendered. **If you receive a statement from us, the balance is due in full. This office does not have a monthly billing system. We only bill once after receiving payment from your insurance company.**

By signing this form, you authorize your insurance company to release payment to . You are also allowing our office to receive, send and request payment and or such collection activities on your behalf.

By signing this form you also understand that you are liable for any remaining balances that your insurance company does not pay for whatever reason.

To ensure you and other patients of our office of uninterrupted treatment, it is necessary for all patients to accept and adhere to our definite policies regarding appointments and fees.

Once an appointment is made, please remember this time is reserved for you: **at least 48-business hour advance notice is required to avoid cancellation charges and fees.** *(Surgery cases require 72-business hour notice)*

If under 18, name of Financially Responsible Party:__________________Relationship:________________

Date of Birth:____________ Social Security Number:______________________ Driver's License #:__________

Address:______________________________City: __________________State:________Zip:________

I consent and agree to the above financial agreement and if applicable, authorize my insurance company to pay all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

______________________________ ________________
Signature of Financially Responsible Party Date

These questions are for your benefit and assure that treatment will take into consideration your past and present health status.
Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health care.
Please answer each question. Check the appropriate box and/or circle **Yes** or **No** where applicable. Example: Are you alive? .... (Yes) No

MEDICAL HISTORY

1. Are you in good health? ....
2. Date of last physical examination .... Yes No
3. Are you now under the care of a physician? ....
   If so, what is the condition being treated? .... Yes No
4. Have you ever had any serious illness or operation? ....
   If so, what illness or operation? .... Yes No
5. Have you ever been hospitalized? ....
   If so, what was the problem? .... Yes No
6. Are you taking any ☐ medications, ☐ drugs or ☐ herbs? ....
   If so, what? .... Yes No
7. Are you using any recreational drugs (marijuana, cocaine, etc.)? ☐ Yes ☐ No If so, what? ________ What dosage? ________
8. Have you ever been pre medicated with antibiotics for your dental treatment? .... Yes No
9. Are you sensitive or allergic to any drugs or materials? ☐ Penicillin; ☐ Tetracycline; ☐ Sulfa Drugs; ☐ Aspirin; ☐ Codeine; ☐ Latex; ☐ Other .... Yes No
   If Other, what drugs? ________
10. Do you have or have you had any of the following: (Please circle 'Y' for Yes or 'N' for No - answer all conditions):

Y N Anemia	Y N Glaucoma	Y N Sleep Apnea	Y N Angina Pectoris	Y N Pain in Jaw Joints	Y N Psychiatric Treatment	Y N Other
Y N Herpes	Y N Tonsillitis	Y N Snoring	Y N Mental Disorder	Y N Artificial Prosthesis	Y N Hepatitis or Jaundice	
Y N Stroke	Y N Hemophilia	Y N Heart Murmur	Y N Thyroid Disease	Y N Sickle Cell Disease	Y N Difficulty Swallowing	
Y N Ulcers	Y N Cold Sores	Y N Liver Disease	Y N Fainting Spells	Y N Cortisone Medicine	Y N Congenital Heart Lesions	
Y N Diabetes	Y N Emphysema	Y N Blood Disease	Y N Rheumatic Fever	Y N Allergies to Metals	Y N Osteoporosis	
Y N Arthritis	Y N Rheumatism	Y N Heart Ailments	Y N Tuberculosis (T.B.)	Y N Excessive Bleeding	Y N X-Ray or Cobalt Treatment	
Y N Asthma	Y N Chicken Pox	Y N Heart Attack	Y N Blood Transfusion	Y N Mitral Valve Prolapse	Y N Radiation Treatment of any kind	
Y N Cancer	Y N Bruise Easily	Y N Cerebral Palsy	Y N Low Blood Sugar	Y N High Blood Pressure	Y N Venereal Disease (Syphilis, Gonorrhea)	
Y N Seizures	Y N Head Injuries	Y N Drug Addiction	Y N Joint Replacement	Y N Low Blood Pressure	Y N Acquired Immune Deficiency Syndrome (AIDS)	
Y N Hay Fever	Y N Heart Failure	Y N Kidney Disease	Y N Nervous Disorders	Y N HIV Related Complex	Y N TMJ (Temporomandibular Joint) Disorder	
Y N Headaches	Y N Scarlet Fever	Y N Chemotherapy	Y N Tumors or Growths	Y N Respiratory Disease		
Y N Implant (s)	Y N Sinus Trouble	Y N Stomach Ulcers	Y N Allergies or Hives	Y N Epilepsy or Seizures		

11. Do you have any disease, condition or problem not listed that you think we should know about? .... Yes No
    If so, what? ________
12. Do you wear a cardiac pacemaker, or have you had heart surgery? .... Yes No
13. Do you smoke? If yes, how much? ____ ☐ Cigarettes ☐ Cigars ☐ Packs per day .... Yes No
14. Have you ever taken the drugs ☐ Fen-Phen, ☐ Redux, ☐ Fosamax (Bisphosphonate), ☐ Zometa, ☐ Actonel, ☐ Boniva, ☐ Aredia, ☐ Diet Drugs? .... Yes No
15. (Women) Are you pregnant? If so how many months? ________ Yes No
16. (Women) Do you have any problems associated with your menstrual period? .... Yes No
17. (Women) Do you take any birth control medication or hormones? .... Yes No

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc.)? .... Yes No
2. Have you ever had any unfavorable reaction from a local anesthetic? .... Yes No
3. Have you had any serious trouble associated with any previous dental treatment? .... Yes No
   If so, explain? ________ Yes No
4. How long since your last full mouth X-Rays? ____ Weeks ____ Months ____ Years
5. How long since your last dental treatment? ____ Weeks ____ Months ____ Years
6. Does dental treatment make you nervous? ☐ Slightly ☐ Moderately ☐ Extremely? .... Yes No
7. Would you desire to be pre-sedated? .... Yes No

(A) Date ________ **Signature** ________

Reviewed by ________ Lic. # ________ Date ________

(B) UPDATE — Since your last visit (A):

1. Have you seen a medical doctor? .... Yes No
2. Have you had a change in your medication? .... Yes No
3. Have you had a change in your medical condition or had surgery? .... Yes No

Please note changes in health since last visit. If no changes, please write "None"

Date ________ **Signature** ________

(C) UPDATE — Since your last visit (B):

1. Have you seen a medical doctor? .... Yes No
2. Have you had a change in your medication? .... Yes No
3. Have you had a change in your medical condition or had surgery? .... Yes No

Please note changes in health since last visit. If no changes, please write "None"

Date ________ **Signature** ________

REVIEWED BY — DO NOT WRITE IN THIS SPACE

REVIEWED BY		(A)	(B)	(C)
(A) DATE	DATE			
(B) DATE	B.P.	/	/	/
	PULSE			
(C) DATE	TEMP			
	BY			

HEALTH QUESTIONNAIRE MUST BE CONTINUALLY UPDATED!

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions printed on the reverse hereof:

Authorization must be signed by the patient, or by the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

Signed: ________ **Date:** ________ **Relationship to Patient** ________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law:. We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services.

A Privacy/Contact Officer has been designated for this office. Please ask our front desk personnel and they will direct you to the Privacy/Contact Officer.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR NECESSARY USE OF PERSONAL HEALTH INFORMATION

____

Print Patient's Name   Date

I, ____, have received
(Signature of Patient or Parent or Legal Guardian)

a copy of this office's NOTICE OF PRIVACY PRACTICES as required by federal law.

I, ____, consent to the use and disclosure of
(Signature of Patient or Parent or Legal Guardian)

my personal health information by your office during Treatment, Billing/Payment and Healthcare Operations as outlined in the Notice of Privacy Practices.

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DENTAL SERVICES AGREEMENT

CHART #____________

________________________________ ("Doctor"), and the undersigned patient ("Patient") have agreed as follows:

ARTICLE 1. IT IS UNDERSTOOD THAT ANY DISPUTE AS TO DENTAL MALPRACTICE, THAT IS AS TO WHETHER ANY DENTAL SERVICES RENDERED UNDER THIS CONTRACT WERE UNNECESSARY OR UNAUTHORIZED WERE IMPROPERLY, NEGLIGENTLY OR INCOMPLETELY RENDERED, WILL BE DETERMINED BY SUBMISSION TO ARBITRATION AS PROVIDED BY CALIFORNIA LAW, AND NOT BY A LAWSUIT OR RESORT TO COURT PROCESS EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OR ARBITRATION PROCEEDINGS, BOTH PARTIES TO THIS CONTRACT BY ENTERING INTO IT, ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF ARBITRATION.

ARTICLE 2. In the event of any claim, demand, controversy or dispute the essential nature of which involves personal injury, malpractice or any tort, by Patient, his dependents, whether or not minors, heirs at law or personal representatives against Doctor or any of Doctor's officers, directors, shareholders, agents, representatives, employees, successors in interests, assigns or associates agreeing in writing to be bound by the arbitration provisions of this agreement (Affiliates"). THE SOLE METHOD FOR RESOLVING SUCH DISPUTE SHALL BE BINDING ARBITRATION ADMINISTERED BY THE AMERICAN ARBITRATION ASSOCIATION in accordance with Commercial Arbitration Rules of the American Arbitration Association. The parties hereby agree that they shall submit their controversy to an Arbitrator, who is a Dentist licensed in California. Such Arbitrator shall be acceptable to both parties. In the event that the parties cannot agree upon a sole Arbitrator, each party shall pick an Arbitrator who is a licensed Dentist in California and the two Arbitrators shall pick a third Dentist proceeding under the rules of the American Arbitration Association. Not withstanding the foregoing, two additional Arbitrators who are Dentists may be added by the parties by agreement in writing to create an arbitration panel of three. It is agreed that all parties relevant to a full and complete settlement of any dispute subject to this agreement may be intervened or joined.

ARTICLE 3. The prevailing party in any arbitration pursuant to this agreement shall be awarded all costs, including reasonable attorneys' fees and the Arbitrators' fees, in prosecuting or defending that claim in arbitration, but not to exceed $5,000 in amount. Furthermore, if any action is undertaken to set aside or otherwise attack the binding arbitration award, the losing party in the court action shall bear all the prevailing party's costs, including reasonable attorneys' fees.

ARTICLE 4. Any party initiating arbitration under this agreement shall file with his petition a bond or cash surety in an amount equal to Five Hundred Dollars ($500) which shall provide security for attorneys' fees and costs in the event that the moving party shall not prevail.

ARTICLE 5. This agreement shall govern all future services rendered to Patient by Doctor and Doctor's Affiliates and Associates. Execution of this agreement is a precondition to the furnishing of services by Doctor, but this agreement may be rescinded by written notice by either party within thirty days of signature. After those thirty days, this agreement may be changed or revoked only by a written revocation signed by both parties.

ARTICLE 6. I understand that each Doctor is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other Doctor or corporate entity, other than the treating Doctor, is responsible for my treatment.

ARTICLE 7. Doctor hereby agrees to render dental care and service to Patient. Patient agrees to pay Doctor promptly upon rendering of a bill at the current prevailing rates, or to cooperate with Doctor in obtaining payment from third party payors.

ARTICLE 8. Except for the fact that Doctor has indicated professional services will not be rendered to Patient unless this agreement is executed, Doctor has made no other representations or statements, oral or written, to induce Patient to execute this agreement.

ARTICLE 9. In the event that any provision of this agreement shall be void or unenforceable for any reason whatsoever, then such provision shall be stricken and of no force and effect. The remaining provisions of this agreement, however, shall continue in full force and effect, and to the extent required, shall be modified to preserve their validity. This agreement shall be governed by California law.

THIS IS A BINDING LEGAL DOCUMENT WHICH MAY HAVE AN IMPORTANT EFFECT OF YOUR LEGAL RIGHTS. CONSULT YOUR ATTORNEY ON ANY QUESTIONS YOU MAY HAVE.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

____
(PATIENT'S SIGNATURE)

____
(PATIENT'S AGENT OR REPRESENTATIVE)

____
(RELATIONSHIP TO PATIENT)

____
(DOCTOR)

DATE OF SIGNING ________________________

______________________________ **AM/PM**

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CALCIFICATION

WHAT IS CALCIFICATION?

Calcification is a process by which the root canal becomes very constricted or closed off over a period of time. This constriction makes it very difficult to pass the small files to the ends of the roots. It is a condition with which your tooth presents, and it makes root canal treatment much more difficult.

The presence of calcification is detected on the dental radiograph (X- ray picture). The root canal may be visible in one part of the root, usually closer to the dental pulp (nerve) chamber, but it may become difficult to see or virtually invisible as the end of the root is approached.

The definition of "calcification" for dental insurance is, "treatment of root canal obstruction non-surgical access: the formation of a pathway to achieve an apical seal without surgical intervention because of a non-negotiable root canal blocked by foreign bodies or calcification of 50% or more of root."

HOW DOES CALCIFICATION FORM?

When the dental pulp is irritated or becomes inflamed due to the presence of deep decay, deep fillings, gum disease, cracks in the tooth, night grinding or other reasons, the nerve reacts by growing protective tooth structure around the circumference of the root canal (channel in the center of the root that contains the nerves and blood vessels.)

The process of calcification is not dependent upon the person's age but is caused by the amount of trauma that the tooth has undergone during its lifetime.

WHY IS CALCIFICATION IMPORTANT?

For endodontic (root canal) treatment to be successful, the root canal has to be cleaned and sealed, using extra techniques as close as possible to the end of the root. When the root canal is calcified, it is much more difficult to find the opening to the canal inside the tooth; it is harder to guide the cleaning instruments to the end of the root, and the procedure takes longer.

When the root canal is severely calcified, there is only a 50% chance, or less that it will be possible to do the root canal treatment/ whether or not the root canals are negotiable can only be determined by attempting to do the root canal treatment. However, it is better to try to save your tooth, if possible, than to lose it.

WHY IS THERE AN EXTRA CHARGE WHEN MY TOOTH IS CALCIFIED?

When the root canal is calcified, more instruments than usual are often required for the treatment. Additional medication and expensive devices are often needed to locate and clean the root canal as thoroughly as possible.

Insurance fees are calculated for the amount of time that a "normal" root canal treatment should take. When the root canal is calcified, additional time, instruments, medication, and expertise are required for successful treatment. It is reasonable to expect that there should be adequate compensation for these "additions."

THE BOTTOM LINE

Calcification is a condition with which your tooth presents, and it must be dealt with so that proper treatment may be provided.

The additional time, instruments, medications, and devices that are required for your root canal treatment.

If the calcified root canal cannot be instrumented to the proper length, then the fee for "calcification" is not charged.

If your tooth cannot be treated successfully; whether due to calcification, or other reasons, then your tooth may have to be extracted.

I have read the above discussion of "Calcification." My questions have been answered.

PRINTED NAME OF PATIENT (PT)	SIGNATURE OF PT (Parent or Guardian if under18)	DATE