ASSOCIATES IN ENDODONTICS

Vincent C. Lovetto Jr., D.M.D.
(239) 261-3017

NEW PATIENT INFORMATION FORM

Last Name_____ First Name_____

Middle Initial_____ Nickname_____Title: Mr. Ms. Mrs. Dr. Fr. Hon. Jr. Sr.

Local Address_____ Zip_____

Local Home Number (_____)_____Social Security Number: XXX-XX- _____

Cell Phone Number (_____)_____E-mail_____

Northern Address _____ Zip_____

Northern Home Number (_____)_____ Work Phone Number (_____)_____

Occupation_____Employer_____

Birthdate_____/_____/_____ Sex: M F Marital Status: S M D W

Spouse's Name_____ Spouse's Occupation_____

Spouse's Employer_____Spouse's Work Number (_____)_____

In an emergency: Contact Name (if other than spouse)?_____Relationship to you?_____
Best Number to reach them: (_____)_____ H W M **Alt.** Number (_____) _____ H W M

Referring Doctor/Patient _____ General Dentist _____

Responsible Party for Payment: Self Parent Spouse Other/Relationship:_____

Responsible Party Name (if other than patient/spouse) _____

Circle Form of Payment: CHECK CREDIT/DEBIT CARD CARE CREDIT CASH

PLEASE NOTE: We do not accept insurance. Payment is due at the time of treatment, however, we will submit the claim to your primary dental insurance company only.

(Please give the Primary Dental Insurance card to front desk to scan. We will submit to the Primary Insurance Company for you.)

Dental Insurance Company Name_____ Dental Ins. Phone Number (_____)_____

Dental Insurance Company Address _____ Zip_____

Subscriber Name _____ Subscriber Number _____ Group Number _____

Subscriber Relation to Patient_____ **Social Security**_____-_____-_____**Birthdate** ____/____/____

Subscriber Employer Name (if different than listed above)_____

Signature _____

01. Are you having pain or discomfort at this time? ..... YES NO
02. Are you currently taking any blood thinners/Anticoagulants? ..... YES NO
03. Have you ever been on any bone density medication or chemotherapy medication? ..... YES NO
04. Have you ever had radiation to your head or neck? When? _____ YES NO
05. Are you currently taking any medications, drugs or pills? ..... YES NO

If yes, please list or provide a list for us to scan:

_____

06. Are you aware of being **allergic** or ever had adverse reactions to any **medication or substance**? YES NO

If yes, please list: _____

08. Have you ever had any joint replacements? YES NO
09. Do you premedicate before dental treatments? YES NO

Indicate which of the following you have had or have at the present: **(PLEASE CIRCLE)** *** = Pre-Med Condition**

HEART PACEMAKER	KIDNEY TROUBLE	HEPATITIS A B C
CONGENITAL HEART DISEASE*	DRUG ADDICTION	VENEREAL DISEASE
ANGINA PECTORIS	TMD (TMJ	A.I.D.S.
HISTORY OF ENDOCARDITIS *	DIABETES	H.I.V. POSITIVE
HEART MURMUR	THYROID PROBLEMS	COLD SORES/FEVER BLISTERS
HIGH BLOOD PRESSURE	GLAUCOMA	BLOOD TRANSFUSION
ARTERIOSCLEROSIS	COSMETIC SURGERY	HEMOPHILIA
MITRAL VALVE PROLAPSE	EMPHYSEMA	ANEMIA
ARTIFICIAL HEART VALVE*	CHRONIC COUGH	SICKLE CELL DISEASE
HEART ATTACK	TUBERCULOSIS	BRUISE EASILY
HEART SURGERY/TRANSPLANT*	ASTHMA	LIVER DISEASE
STROKE	NERVOUSNESS	PSYCHIATRIC TREATMENT
ARTHRITIS	VERTIGO	EPILEPSY OR SEIZURES
RHEUMATISM	SINUS TROUBLE	ARTHRITIS
ARTIFICIAL JOINTS (HIP, KNEE, ETC.)*	RADIATION THERAPY	CHEMOTHERAPY

IF CIRCLED, PLEASE EXPLAIN: (When, Still in treatment, etc.): _____

_____

09. Do you have or have you had any disease, condition, or problem not listed? ..... YES NO

If yes, please list: _____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner.
I have answered all questions truthfully and to the best of my knowledge.

_____ _____

Patient Signature **Date**

FOR FEMALES ONLY: Are you pregnant? YES NO If yes, what month are you in? _____
Are you nursing? YES NO Are you taking Birth control? YES NO

ASSOCIATES IN ENDODONTICS

INFORMED CONSENT

1. If today's appointment is for a consultation, CT scan, or an evaluation, the fee range is approximately $100-$300 depending upon the test performed and x-rays taken.

2. The purpose of root canal therapy is to retain teeth that would otherwise have to be extracted.

3. Treatment will require a series of diagnostic radiographs and may require multiple visits. It is important that you maintain scheduled appointments or the infection can reoccur.

4. In most cases, there is only mild discomfort following each treatment. This is usually controlled with aspirin, Tylenol, ibuprofen, or prescribed medication.

5. Endodontic treatment has a high degree of success (approximately 90-95%). As with any medical or dental treatment, however, this treatment has no guarantee of success for any length of time. Teeth with previous root canal treatment tend to have a lower success rate.

6. Accurate and complete disclosure of medical information is necessary for proper diagnosis, and to help prevent unnecessary complications during your treatment.

7. The most common complications with root canal therapy include, but are not limited to:
    A. Continued infection requiring endodontic (root canal) surgery or extraction of the tooth.
    B. Calcified canals or canals blocked by separated instruments requiring endodontic (root canal) surgery or extraction of the tooth.
    C. Pain, requiring use of medication.
    D. Side effects and reactions to medication.
    E. Fractures (breaking) of the root or crown of the tooth during or after treatment. It is recommended that all posterior teeth be crowned following root canal treatment. If your tooth already has a crown, there is a chance it will need to be replaced due to decay or loss of structural support. Porcelain crowns are subject to breakage.
    F. Tenderness of the tooth following treatment due to possible complications with root canal treatment, gum disease, physical stress from chewing, or the degree of healing your body exhibits.

8. Other treatment choices include no treatment, waiting for more definite development of symptoms, and tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infection to other areas.

"I have read and understand the above, and hereby consent to endodontic consultation and/or treatment."

_____ _____

Signature of Patient, Parent, or Guardian **Date**

ASSOCIATES IN ENDODONTICS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address _____

Telephone: _____ Email: _____

Patient #: _____ Social Security # _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENT CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of privacy practices. If we change our privacy practices, we will issue a revised Notice of Privacy practices, which will contain the changes. Those changes may apply to any of your protected health information that that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Contact Person: Vincent Lovetto Jr.

Telephone: 239-261-3017 Fax: 239-261-0454

Email: info@aie-naples.com

Address: 3641 10th ST N Suite A Naples, FL 34103-3810

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature

I, _____, have had a full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative of behalf of the patient, complete the following:

Minor Patient's Name (Printed): _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include Completed Consent in the patient's chart.

NOTICE OF PRIVACY PRACTICES (DENTAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED;
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or rnore health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14th, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact our office for more information:

Associates in Endodontics, PA
3641 Tenth Street North
Naples, FL 34103
OFC (239) 261-3017
FAX (239) 261-0454

For more information about HIPAA or to file a complaint:

The U. S. Department of Health & Human Services Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
TOLL- FREE: 1-877-696-6775

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I have reviewed this office's Notice of Privacy Practices and **would like** (_____) /**decline** (_____) a copy for my records.

_____ _____ _____
Please Print Name Please Sign Name Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
____ Individual Refused to Sign ____ Communication Barriers Prohibited Obtaining ____ An emergency situation prevented us from obtaining ____ Other (Please Specify):