Holley
ENDODONTICS

GABRIEL M. HOLLEY, D.D.S., M.S.

Date:________________

Name: ________________________ ________________________ ________
First Last Middle Initial

Home Phone:(______) ________-__________ **Business Phone:**(______) ________-__________

Home Address: ____
Street Apt. No.

City ______________________ **State** __________ **Zip** __________ **Email:**________________

Date of Birth _____/_____/_____ **Sex: M or F** **Marital Status:** Single Married Other

SS#______-_____-_______ **Driver's License #:**______________________________

You will be asked to present a copy of your driver's license as proof of identity. A photocopy will be placed in your chart.

Employer: ________________________ **Name of General Dentist:** ________________

Who is responsible for your account?:________________________ Relationship to patient: SPOUSE CHILD OTHER
(skip if same as above) First Last

Address: ________________________ City________________ State_____ Zip ____________

Home Phone: (______) ______-_______ Business Phone:(______) ______-_______

Do you have DENTAL insurance? Yes or No

If yes, Name of Insurance Company ________________________________

Group # ____________________

Are you the insured? Yes or No If no, name of insured:________________________
First Last

Relationship to the patient: SPOUSE CHILD OTHER: ____________

Insured's Date of Birth: ____/____/____ **SS#**_____-_____-_____ **Employer** ________________

Holley Endodontics, P.A.
Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Please note that the Notice of Privacy Practices is posted in the office of Gabriel M. Holley, D.D.S. A copy of this notice is available upon request. In signing below, I am acknowledging that I have been made aware of the posted Notice of Privacy Practices.

________________________ ______________
Signature Date

Please indicate the method by which you prefer our office to contact you:

- __**Home Phone**
- __**Business Phone**
- __**Email**
- __**Other** ____________

If we are unable to reach you directly, may we leave a message either on an answering machine or with a person at the indicated number above? YES or NO

Go to next page

Our Financial Policy
(Please read the policy and sign.)

We are delighted to have you as a dental patient. Our goal is to provide the highest quality endodontic treatment to our patients. Please read and sign the financial policy below. If you have any questions, please do not hesitate to ask our staff. We will need a copy of your dental insurance card (if applicable). In order for us to file your dental claims, we must have your social security # or ID # listed on your insurance policy. If you do not want to disclose this information, you will be asked to pay in full at the time of your procedure(s), as we will not be able to file the claim for you. Thank you.

Payment is due at the time services are rendered.

ATTENTION PATIENTS WITH DENTAL INSURANCE:

As a courtesy to you, insurance forms will be filed for you. You will be responsible for the deductible and a percentage of the fee that your insurance company considers to be your estimated portion. Please be prepared to pay your deductible and the estimated patient portion at the time of your appointment. Please understand that although certain services provided may not be covered by your insurance company, it is still your responsibility to pay for these services. You will be billed for any balances not paid by your insurance company. And likewise, we will gladly and promptly refund to you any funds due to you upon payment by your insurance company, if applicable. We will file for primary insurance carriers only, although we will be glad to assist your efforts in filing all claims.

If you have been quoted an estimated portion of the fee due at the time services are rendered (sometimes referred to as the patient's co-pay), please remember this quote is an ESTIMATE. Your insurance company clearly states that there is NO GUARANTEE OF COVERAGE OR PAYMENT, and this coverage cannot be determined until the actual insurance claims are processed. After the insurance claim has been processed, any remaining balance is the patient's responsibility.

Remember, your insurance is a contract between you and your insurance company. Holley Endodontics is NOT a participating provider with any dental insurance plan, we will gladly assist you with filing your claim, however, **the ultimate responsibility for payment is with the patient.** If payment is not received from your insurance company within 30 days of the date of your procedure(s), you will be expected to pay the balance on your account at this time. In this instance, our office would continue to aid you in the effort to collect your insurance payment.

I authorized my insurance company to issue dental benefits directly to this dental office, and I also authorize the release of any information necessary to process the dental insurance claims (if applicable).

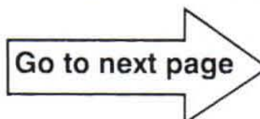
Please check your preferred method of payment: ____ Cash ____ Check ____ Credit Card ___________

In the unfortunate circumstance of a delinquent account or a returned check, please note that you will be charged for any fees our office assumes through collections or through the court system in an effort to collect the balance owed. A $30.00 fee will be charged for any check returned to our office, and this fee may be electronically withdrawn from your checking account.

If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs.

I have read and understand the financial policy. Once you have signed this agreement, you agree to all of the terms and conditions contained herein, and the agreement will be in full force and effect.

______________________________	______________	
Patient's Signature	Date	
______________________________	______________	______________
Responsible Party (if not the patient)	Date	Relationship to Patient



Endodontic Consent and Information Form

Endodontic Root Canal Therapy, Endodontic Surgery, Anesthetics, and Medications

We would like our patients to be informed about the various procedures involved in endodontic therapy and have their consent before starting treatment. Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by conservative root canal therapy, or when needed, endodontic surgery. The following discusses the possible risks that may occur from endodontic treatment and other treatment choices.

RISKS: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesic (pain killers), anesthetics, and injections. These complications include: swelling; sensitivity; bleeding; pain; infection; numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is transient but on infrequent occasions may be permanent; reaction to injections; changes in occlusion (biting); jaw muscle cramps and spasms; temporomandibular (jaw) joint difficulty; loosening of teeth; referred pain to the ear, neck and head; nausea; vomiting; allergic reactions; delayed healing; sinus perforations; and treatment failure.

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 may require dental surgery. These complications may include; blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), splits or fractures of teeth.

MEDICATIONS: Prescribed medications and drugs may cause drowsiness and lack of awareness and coordination (which may be influenced by the use of alcohol, tranquilizers, sedatives, or other drugs). It is not advisable to operate any vehicle or hazardous device until recovered from their effect.

TREATMENT SUCCESS: According to more contemporary research, 90-95% of teeth treated by initial root canal therapy will be successful if bone loss has not occurred at the end of the root. Several factors such as previous root canal treatment, fractures, and bone loss at the end of the root can decrease this prognosis. We will make every effort to help you preserve your natural tooth, however, endodontics, as with any branch of medicine is not an exact science and no guarantee of treatment success can be given or implied. If a root canal is determined to be unsuccessful, the root canal may be redone, endodontic surgery may be required, or the tooth may have to be extracted at additional fees.

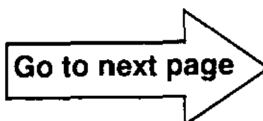
OTHER TREATMENT CHOICES: These include no treatment, waiting on more definite development of symptoms, and tooth extractions. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infection in other areas.

CONSENT: I, the undersigned, being the patient (parent or guardian of the above minor patient) consent to the performing of procedures decided upon to be necessary or advisable in the opinion of my doctor. I also understand that upon completion of root canal therapy in the office I SHALL RETURN TO MY GENERAL FAMILY DENTIST FOR A PERMANENT RESTORATION OF THE TOOTH INVOLVED, such as a crown, cap, jacket, inlay, or silver filling.

If health care workers are accidentally exposed to my blood or other bodily fluids in the course of providing treatment to me, I agree to have my blood tested for any infectious diseases which could have been transmitted to them through this exposure.

____
Print Patient's Name

________	______________________	______________________
Date	Witnessed By	Patient/Parent Signature



HEALTH QUESTIONS:

Patient's Name: ______________________________ **Date** ____/____/____
First Last

Physician's Name: ______________________________

In Case of Emergency, Contact: ______________________ **Phone:**____-________
First Last

DUE TO A MEDICAL CONDITION, SUCH AS A HEART MURMUR, JOINT REPLACEMENT, RHEUMATIC FEVER, ETC. DO YOU REQUIRE PREMEDICATION BEFORE ALL DENTAL PROCEDURES? YES or NO

If you answered yes to the above question, have you taken your premed today? YES or NO

Is a physician treating you for illness? YES or NO

Are you pregnant? (If applicable) YES or NO

Are you subject to prolonged bleeding? YES or NO

Do you have or have you ever had any of the following? Please check all that apply.

Cardiovascular
- ☐ Angina/Chest Pain
- ☐ Congestive Heart Failure
- ☐ Heart Attack/Failure
- ☐ Heart Surgery
- ☐ Heart Trouble/Disease
- ☐ High/Low Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Pacemaker
- ☐ Artificial Heart Valves
- ☐ Heart Malformation
- ☐ Heart Murmur
- ☐ Heart Valve Infection
- ☐ Rheumatic Heart Disease

Endocrine
- ☐ Adrenal Gland Tumor
- ☐ Diabetes
- ☐ Thyroid (Hyper/Hypo)
- ☐ Sjogren's Syndrome

Gastrointestinal
- ☐ Peptic Ulcer Disease
- ☐ GI Disease

Hemotologic
- ☐ Anemia
- ☐ Bleeding (Excessive)
- ☐ Hemophilia
- ☐ Platelet Disorder
- ☐ Sickle Cell Anemia

Hepatic/Renal
- ☐ Dialysis
- ☐ Hepatitis Type ______
- ☐ Liver Disease
- ☐ Kidney Disease

Immune
- ☐ AIDS/HIV
- ☐ Leukemia
- ☐ Systemic Lupus

Muscular Skeletal
- ☐ Arthritis/Gout
- ☐ Artifical Joint(s)
- ☐ Fibromyalgia

Neurologic
- ☐ Seizures
- ☐ Stroke

Psychiatric
- ☐ Chemical Dependency
- ☐ Psychiatric Care

Respiratory
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Emphysema (COPD)
- ☐ Frequent Cough
- ☐ Tuberculosis
- ☐ Sinus Trouble

General
- ☐ Cancer
- ☐ Organ Removal
- ☐ Organ Transplant
- ☐ Radiation Therapy

Allergies:
- ☐ NONE
- ☐ Penicillin
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Tylenol
- ☐ Codeine
- ☐ Epinephrine
- ☐ Nitrous
- ☐ Latex
- ☐ Sulfa
- ☐ Other:

Please List: ______________________

____

Medications:

Are you taking any of the following?

- ☐ NONE
- ☐ Aspirin ______________________
- ☐ Antibiotics ______________________
- ☐ Antidepressants ______________________
- ☐ Birth Control Pills ______________________
- ☐ Bisphosphonates (i.e. Fosamax) ______________________
- ☐ Blood Pressure Medicine ______________________
- ☐ Blood Thinner ______________________
- ☐ Cortisone/Steroids ______________________
- ☐ Heart Medicine ______________________
- ☐ Hormones ______________________
- ☐ Insulin ______________________
- ☐ Pain Medicine ______________________
- ☐ Thyroid Medication ______________________
- ☐ Ulcer Medication ______________________

Additional information: Please list other medications/conditions/major surgeries: ______________________

____

____

____

Office Use Only Update ____/____/____ Update ____/____/____ Update ____/____/____ Update ____/____/____

FORM 119321 N/09/17 ITEM 8101

Please take a moment to answer a few questions concerning
the tooth or teeth that you will have evaluated and/or treated today.

NAME: ____________________________________

DATE: ______________

Are you having any pain associated with
your tooth ? YES or NO

If yes, how would you describe the pain?
Circle the words that apply: - DULL or THROBBING or SHARP

- CONSTANT or INTERMITTENT

- SEVERE or UNCOMFORTABLE

How long have you been having symptoms
(pain/swelling, etc) associated with this
tooth? ____________________________________

Is the tooth sensitive to HOT? YES or NO
Is the tooth sensitive to COLD? YES or NO

Does the tooth hurt when you bite down? YES or NO

Does the pain wake you up at night? YES or NO

Are you experiencing any swelling ? YES or NO

Office Use Only

Tooth # ______	Canals	Lengths
	____	____
	____	____
	____	____