

# **HOBEICH ENDODONTICS**



**PAUL HOBEICH, D.M.D.**  
**YOUR ROOT CANAL SPECIALIST**

## **Patient Information**

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home#** \_\_\_\_\_ **Cell#** \_\_\_\_\_ **Work#** \_\_\_\_\_

**Employer/phone #** \_\_\_\_\_

**RESPONSIBLE PARTY:** \_\_\_\_\_ **Phone #** \_\_\_\_\_

## **INSURANCE INFORMATION**

**DENTAL INS.** \_\_\_\_\_

**SECONDARY INS.** \_\_\_\_\_

**GROUP NO.** \_\_\_\_\_ **I.D./SS#** \_\_\_\_\_

**POLICYHOLDER IF DIFFERENT FROM ABOVE:** \_\_\_\_\_

**SS#** \_\_\_\_\_ **D.O.B** \_\_\_\_\_

## **RELEASE/CONSENT:**

This is my consent for the doctors of **HOBEICH ENDODONTICS** to perform any necessary dental procedure(s) as indicated by my dental examination. I understand that although root canal has a high degree of success, it is still a biological procedure, and therefore success cannot be guaranteed. I have been informed and understand that there are certain inherent and potential risks in a treatment procedure. These risks may include, but are not limited to, swelling, infection, bruising, discomfort, and fractures of teeth and existing restorations.

I understand that variations in tooth anatomy and canal shape may complicate treatment and could result in a perforation (hole) in the root or separation of a metal root canal instruments in the tooth. Additional treatment, surgical repair, or extraction may be necessary to resolve these problems.

I have been informed of possible alternative treatments including extraction and non-treatment and the possible benefits or adverse results from these alternative treatments. I understand that a permanent restoration (filling or crown) is to be done by my restorative dentist. I also understand that failure to have the permanent restoration completed may lead to failure of the root canal therapy as well as possible fracture and/or infection of the treated tooth. This may result in the necessity for additional treatment or extraction of the previously treated tooth.

**I understand that root canal therapy is to be rendered if determined diagnostically.**

**THERE WILL BE A \$50.00 FEE APPLIED FOR NO SHOWS AND OR CANCELLATIONS WITHOUT 24HR .PRIOR NOTICE.**

**PATIENT (GUARDIAN)** \_\_\_\_\_ **DATE** \_\_\_\_\_ **WITNESS** \_\_\_\_\_

# HOBENCH ENDODONTICS



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## MEDICAL HISTORY

*Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information. For the following questions, please mark **Yes** or **No**. Please note you may be additional questions concerning your health.*

Are you currently under the care of a physician?  Yes  No

Name of Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Are you currently in good health?  Yes  No

In the last year, have there been any changes in your general health?  Yes  No

My last physical examination was on: \_\_\_\_\_ (mm/yyyy)

If so, what is the condition are being treated for?

Have you had any serious illness or hospitalizations in the last 5 years?  Yes  No

If yes, what was the illness or problem:

Are you currently taking or have your recently taken any prescription  Yes  No

or over the counter medicine(s)?

If so, please list all, including vitamins, natural or herbal and/or diet supplements:

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<b>Allergies: if YES please specify type of reaction.</b>			
Local anesthetics: _____.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Aspirin/NSAIDs: _____.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Penicillin or other antibiotics: _____.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Barbiturates, sedatives, or sleeping pills: _____.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Sulfa Drugs: _____.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Codeine/Narcotics: _____.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Metals: _____.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Latex: _____.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Seasonal Allergies: _____.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Animals: _____.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Food: _____.			<input type="checkbox"/> Yes <input type="checkbox"/> No
Other: _____.			<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Please mark (X) your response to indicate if you have or have not had any of the following disease or problems</b>			
Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral valve prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial heart valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer/chemo/rad treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest pain upon exertion	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiovascular disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chronic pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes type 1 or 2	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arteriosclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eating disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Congestive heart failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Malnutrition	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coronary artery disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gastrointestinal disease (reflux)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Damaged heart valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heartburn	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No
Low blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital heart defects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis/jaundice/liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormal bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures or fainting spells	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood transfusion (Date: _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Night sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Autoimmune disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Persistent swollen neck glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatoid arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Severe headaches/migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No
Systemic lupus erythematosus	<input type="checkbox"/> Yes <input type="checkbox"/> No	Severe or rapid weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexually transmitted disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive urination	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you wear contact lenses	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neurological disorders (If yes, specify: _____.)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mental health disorders (If yes, specify: _____.)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Recurrent infections (If yes, specify: _____.)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
AIDS or HIV infection (If yes, CD4: _____ Viral load: _____.)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you taking, or have taken, and diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you taking or scheduled to take the medications alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? If yes when did treatment begin: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use controlled substances (drugs)? (If yes, specify: _____)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use Tobacco (smoking, snuff, chew, bidis)? (If yes, specify: _____)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you drink alcoholic beverages? If yes, how much in the last 24 hours? _____. How much in a week? _____.		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Joint Replacement:</b> Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? Date: _____ Any complications: _____.		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Women Only:</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pregnant? (If yes, number of weeks: _____.)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Taking birth control pills or hormonal replacement?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Nursing?		<input type="checkbox"/> Yes <input type="checkbox"/> No	

If there are others, please describe: \_\_\_\_\_  
\_\_\_\_\_

Have you ever had problems with previous dental treatment?  Yes  No  
If yes, please describe: \_\_\_\_\_

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## **FINANCIAL AGREEMENT**

Thank you for choosing us to provide your endodontic care. We consider it an honor to have been chosen by you. Our philosophy in serving people is to be informative, honest and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask our business office staff.

### **DENTAL INSURANCE**

As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you and not your insurance company.
- You are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable" all of which vary from one company to another.

**Your signature indicates your acceptance of responsibility to pay regardless of our estimate.**

- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and co-payments are due at the time of treatment.

### **PAYMENT POLICY**

- We accept cash, personal checks, debit cards, Visa, MasterCard, American Express, and Discover. For those who qualify, we also accept Care Credit . Care Credit options allow no interest financing for up to twelve months. If you choose to pay cash in full, on or before the treatment day we will gladly extend a 5% cash savings.
- After dental insurance has paid its portion, a statement is sent to the mailing address on record, for the remaining balance. Payment is expected within 25 days of the statement date, to avoid finance charges.
- **If the insurance company does not pay in full within 45 days, it will be your responsibility.**

### **RETURNED CHECKS**

- A **\$40.00** charge applies when a check is returned by the bank.

### **Missed Appointment Fee**

- If you need to reschedule or cancel an appointment, you must notify us at least twenty-four (24) hours in advance to avoid a **missed appointment fee of \$50**. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.
- Broken appointments prevent others from receiving the dental care they deserve. We take them seriously so please be considerate and inform us in advance if you need to change your appointment.

### **CONSENT & AUTHORIZATION**

I, do hereby authorize dental treatment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understand this document in its entirety, outlining office policies and financial policies of **HOBEICH ENDODONTICS LLC**. Without any reservations, I agree to abide by the policies outlined herein.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# **HOBELCH ENDODONTICS**



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## **HIPAA ACKNOWLEDEMENT**

### **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/20/2011, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time.

### **USES AND DISCLOSURES OF HEALTH INFORMATION**

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. All emails containing treatment information are sent via non-encrypted email, if you choose not to have your information sent via non-encrypted email please notify the staff so the information can be sent using an alternative method.

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

**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. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect ,unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** Per your request, we may disclose your health information to a family member , friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**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.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to you with appointment reminders (such as phone call, emails, 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. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information). You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request an alternative format, we will charge a cost – based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_