## MEDICAL AND PERSONAL HISTORY

**CONFIDENTIAL** PLEASE PRINT DATE: _____

Patient's Name: _____ Age: _____ Birthdate: _____ Sex: M F

Responsible Party: _____ Relationship to Patient : _____

Address: _____

City, State, Zip: _____ Patient's SSN: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Name of Dentist/Person who referred you to our office: _____

Primary Dental Ins. Carrier: _____ Group (Acct) # _____

Subscriber Name: _____ Birthdate: _____ ID/SSN #: _____

Mailing Address: _____

Employer that carries benefits: _____

Secondary Dental Ins. Carrier: _____ Group (Acct) # _____

Subscriber Name: _____ Birthdate: _____ ID/SSN #: _____

Mailing Address: _____

Employer that carries benefits: _____

HEALTH HISTORY:

1. Circle any of the following which you have or have had in the past:

| | | | |
|---|---|---|---|
| Heart Trouble | Stroke | Pacemaker | Yellow Jaundice |
| High Blood Pressure | Kidney Trouble | Thyroid Disease | Blood Transfusion |
| Heart Murmur | Anemia | X-ray or Cobalt Treatment | Drug Addiction |
| Rheumatic Fever | Lung Disease | Chemotherapy | Hemophilia |
| Congenital Heart Valve | Tuberculosis (TB) | Cortisone Medicine | Venereal Disease |
| Artificial Joints | Asthma | Pain in Jaw Joints/TMJ | Epilepsy / Seizures |
| AIDS/HIV | Sinus Trouble | Hepatitis A, B, C, D | Stomach Ulcers |
| Prolonged Bleeding | Liver Disease | Arthritis | Allergies / Hives |
| Diabetes | | | Latex Allergy |

2. Are you having pain or discomfort at this time? ..... Yes No
3. Are you allergic to or made sick by any medication? ..... Yes No
   If so, What? _____
4. Have you ever had a reaction to an anesthetic injection (Novocaine)..... Yes No
5. Do you have any disease, condition or problem not listed? ..... Yes No
   If yes, please explain - _____
6. If female, are you pregnant, breast feeding or taking oral contraceptives? ..... Yes No

Please list ALL MEDICATIONS you are taking (including aspirin, birth control pill, etc.) _____

_____

_____

Family Physician: _____ Phone : _____

Emergency Contact: _____ Phone: _____ Relationship: _____

I have answered these questions to the best of my knowledge.

(X) _____

PATIENT'S SIGNATURE (Guardian if under the age of 18)

# Endodontics of Las Vegas

Chase E. Crowley, DDS, MS
Daryl Grigsby Jr., DMD, MS
Darin K. Kajioka, DDS, MSD
9750 Covington Cross Dr., Suite 150
Las Vegas, Nevada 89144
702-878-8584


## Endodontic Information and Consent

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

**General Risks of Dental Care:** Included (but not limited to) are complications resulting from the use of dental instruments and medicines such as: antibiotics, analgesics (pain killer), local anesthetic injections & root canal filling material. These complications may include swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth (which is usually transient but on infrequent occasions may be permanent), reactions to injections, changes in occlusion (biting), jaw, ear neck, and head, nausea, vomiting, allergic reactions, delayed healing, sinus perforations and treatment failures.

**Risks More Specific to Endodontic Therapy**: The risks include the possibility of instruments breaking 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 make treatment impossible or which may require corrective dental surgery. These complications may include blocked canals due to fillings or prior treatments, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), and splits or fractures of teeth.

**Other Treatment Choices:** These include no treatment, waiting for more definitive development of symptoms and tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth and spread of infection to other areas. The risks of these alternative treatments are often more severe than those of root canal therapy.

**Consent:** I, the undersigned, being the patient (or parent or guardian of minor patient) consent to performing the procedures decided to be necessary or advisable in the opinion of Dr. Chase E. Crowley, Dr. Darin K. Kajioka or Dr. Daryl Grigsby, Jr. I also understand that upon completion of root canal therapy in this office, I shall return to my general dentist for a permanent restoration such as a crown, onlay, or filling.

I understand that root canal treatment is an attempt to retain a tooth which may otherwise require extraction. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth that had root canal therapy may require retreatment, corrective surgery, or even extraction.

I hereby state that I have read and understand this consent. I have been given the opportunity to question the doctor, and all questions about the procedure(s) have been answered in a complete and satisfactory manner. This consent form does not encompass the entire discussion I had with Dr. Crowley, Dr. Kajioka or Dr. Grigsby regarding the proposed treatment.

_____ _____

Patient/Guardian Signature Date

# Endodontics of Las Vegas

Darin K. Kajioka DDS, MSD
Chase E. Crowley DDS, MS
Daryl Grigsby Jr., DMD MS
9750 Covington Cross Dr., Suite 150
Las Vegas, NV 89144
702-878-8584


## Financial Policy

The major objective of this office is to provide you with the best quality dental care available anywhere. This service is based on a friendly and professional understanding between doctor and patient. The Following statements are made to acquaint you with our financial policy:

- Patients are required to pay in full for all services rendered at the time of the visit. Forms of payment accepted are Cash, Check (with proper identification), Care Credit, Visa, Master Card, American Express, and Discover Card. If payment is a problem, please let us know before the start of the treatment.

- We will be happy to assist you in submitting your insurance claims upon completion of treatment. The patient needs to realize that the insurance agreement is between the insurance company and the patient, and not the doctor. Insurance companies determine the amount of coverage for each individual. If your insurance company does not accept "Signature on File" for assignment of benefits, you must pay your entire balance at the time of service.

- Fees quoted at the initial appointment are an estimation and are subject to change after the insurance has been billed. Fees normally will not increase **EXCEPT** when the insurance company denies payment, insurance benefits have exhausted, appointments are broken, unforeseen complications during treatment or surgical intervention becomes necessary.

- If Pre-Authorization has been done by our office prior to your visit, please be advised that the patient copay amount is just an estimate and all benefits will be determined by your insurance company at the time the actual service claim is submitted. The patients are responsible for all charges incurred not paid by the insurance company.

- In case of broken appointments with less than 24 hours notice, an additional fee of $50.00 will be charged to the patient.

- Any checks returned to our office unpaid will be charged a $25.00 fee.

- Our fees do not include the permanent filling or crown which should be completed by your general dentist after completion of endodontic therapy.

Please understand that if payment is not made when due, the account may be turned over for collection. You will be responsible for any and all cost associated with the collection procedure, including but not limited to billing cost, collection fees, and all court cost.

I hereby state that I have read and understand the office financial policies.

_____ _____

Patient /Guardian Signature Date

**Endodontics of Las Vegas**
Chase E. Crowley, DDS, MS
Daryl Grigsby Jr., DMD, MS
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9750 Covington Cross Dr., Suite #150
Las Vegas, NV 89144
702-878-8584

I hereby authorize the release of information strictly pertaining to my treatment to my insurance provider and or my general dentist. I understand that I am responsible for all cost of dental treatment.

_____ _____

Signature of PATIENT or GUARDIAN of PATIENT Date

I hereby authorize payment directly to the above-named dentist of the insurance benefits otherwise payable to me.

_____ _____

Signature of PATIENT or GUARDIAN of PATIENT Date

# Endodontics of Las Vegas

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702-878-8584


## Informed Consent for Controlled Substance Therapy for Pain

In Nevada, per Assembly Bill 474, prescribers must inform their patients of information regarding the treatment of pain with the use of a controlled substance. It is important that you review the following information carefully and request additional information you may need to make an informed choice about the medication(s) prescribed. Please review the information listed here and initial each item.

_____ I understand that I am being prescribed medications, including controlled substances for the treatment of pain.

_____ I understand that all pain medications, including controlled substances, have different benefits and risks in the treatment of my symptoms. I have been advised of the potential risks and benefits of treatment using controlled substances.

_____ I understand that prescription-controlled substances can carry serious risks of addiction and overdose, especially with prolonged use.

_____ I understand that I am not to use the controlled substance prescribed to me in conjunction with drugs or alcohol, or other medications (unless otherwise directed by my prescriber).

_____ Before I was prescribed this pain medication, I was advised regarding non-opioid alternative means of treatment for my symptoms, including but not limited to anti-inflammatories (i.e., Aleve, Tylenol, Ibuprofen, etc.)

_____ I understand that when I take controlled substance(s), I may experience certain reactions or side effects that could be dangerous, including, but not limited to, sleepiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing of my breathing.

_____ I understand that when I take controlled substance(s), it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel sedated, confused or otherwise impaired by these medications, I understand that I should not do things that would put myself or other people at risk for being injured.

_____ I understand that when I take controlled substances, I may become physically dependent of them, meaning my body will become accustomed to take the medications every day, and I would experience withdrawal sickness if I stop them or cut back on them too quickly. Withdrawal symptoms feel like having the flu, and may include abdominal pain, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, yawning, anxiety, and sleep problems.

****Please complete and sign both front and back of consent form****

_____ I understand that I may become addicted to controlled substances and require addiction treatment if I cannot control how I am using them, or if I continue to use them for a prolonged period of time. I have discussed with my prescriber the proper use of the controlled substance.

_____ I understand that anyone can develop an addiction to pain medications, but people who have had problems with mental illness or with controlling drug or alcohol use in the past or who have a parent or sibling who has had drug or alcohol abuse problems are at higher risk. I have told my prescriber if I or anyone in my family has had any of these types of problems.

_____ I understand that I must store prescriptions in a secure place and out of reach of children, other family members and others and/or use a locked medicine cabinet. To safely dispose of unused medications, I can return the unused medications in the bottle to a local pharmacy, a local drug-take back day, or a local police or sheriff substation in my community, or I may safely dispose of them by dissolving them in a Dettera pouch. I understand that I am not to dispose of unused medications into the toilet or sink.

_____ I understand that my doctor may not be permitted to refill my medication via telephone and, therefore, any requests for refills may require a consultation appointment. I understand that my doctor may decline to refill my prescription if s/he believes it to be medically unnecessary and/or harmful to my well-being. I understand that I am being prescribed a controlled substance for a short duration and that prescriptions for additional periods of time may require additional consultation, assessment and agreements.

_____ I understand that due to the risk of possible overdose resulting from of controlled substances, the opioid overdose antidote naloxone (Narcan ®) is now available without a prescription. I may obtain naloxone (Narcan ®) from a pharmacist.

_____ For **Women:** It is my responsibility to tell my prescriber immediately if I think I am pregnant or if I am thinking about getting pregnant. I understand the risk to a fetus of chronic exposure to controlled substances during pregnancy, including, without limitation, the risks of fetal dependency on the controlled substance, neonatal abstinence syndrome, neurologic and heart problems in the baby, prematurity, and fetal or neonatal death.

**Informed Consent:**
I understand each of the statements written here and by signing give my consent for treatment of my pain condition with medications, including controlled substances. I have had the opportunity to ask any questions that I may have regarding my treatment of pain with medications, including controlled substances, and am satisfied that my questions have been answered.

| | | |
|---|---|---|
| **Patient Name printed** | **Patient Signature** | **Date** |

**Unemancipated Minor:**
As the Parent/Guardian, I have discussed with the prescriber the risks that the minor will abuse or misuse the controlled substance or divert the controlled substance for use by another person and ways to detect such abuse, misuse or diversion.

| | | |
|---|---|---|
| **Patient/Guardian Name printed** | **Patient/Guardian Signature** | **Date** |

# NOTICE OF PRIVACY PRACTICES

Endodontics of Las Vegas
9750 Covington Cross Drive, Suite 150
Las Vegas, Nevada 89144

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.

This notice takes effect on _____ and remains in effect until we replace it.

## 1. OUR PLEDGE REGARDING DENTAL INFORMATION

The privacy of your dental information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our dental office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share dental information about you. We also describe your rights and certain duties we have regarding the use and disclosure of dental information. Throughout this notice we refer to your medical information as dental information.

## 2. OUR LEGAL DUTY

Law Requires Us to:

1 . Keep your dental information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your dental information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all dental information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

## 3. USE AND DISCLOSURE OF YOUR DENTAL INFORMATION

The following section describes different ways that we use and disclose dental information. For each kind of use or disclosure, we will explain what we mean and give an example. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose dental information. We will not use or disclose your dental information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use dental information about you to provide you with dental treatment or services. We may disclose dental information about you to doctors, nurses, technicians, or other people who are taking care of you. We may also share dental information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your dental information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your dental information.



FOR HEALTH CARE OPERATIONS: We may use and disclose your dental information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your dental information for treatment, payment, and hea lth care operations, we may use and disclose dental information for the following purposes.

Notification: We may use and disclose dental information to notify or help notify: a family member, your personal representative or another person responsible for your care. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, dental supplies, x-ray or other dental information for you.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of dental information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the dental information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use dental information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose dental information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your dental information with law enforcement officials. We may share limited information with a law enforcement official concerning the dental information of a suspect, fugitive, material witness, crime victim or missing person. We may share the dental information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your dental information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your dental information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose dental 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 share your dental information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share dental information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose dental information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

***Law Enforcement:*** Under certain circumstances, we may disclose dental information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

***Appointment Reminders:*** We may use and disclose dental information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

***Alternative and Additional Dental Services:*** We may use and disclose dental information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

## 4. YOUR INDIVIDUAL RIGHTS

***You Have a Right to:***

1. Look at or get copies of certain parts of your dental information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $ Ø for each page, and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your dental information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your dental information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your dental information by different means or to different locations. Your request that we communicate your dental information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your dental information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

## 5. QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

9750 Covington Cross Dr
Suite 150
Las Vegas, NV 89144

You may also 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. We will not retaliate in any way if you choose to file a complaint.

# PRIVACY PRACTICES ACKNOWLEDGEMENT

## ACKNOWLEDGEMENT FORM

**I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.**

**Name**_____**Birthdate**_____

**Signature**_____**Date**_____