Tennessee Valley ENDODONTICS

Barton T. Barrett, DMD

NEW PATIENT INFORMATION

Last Name _____ First _____ Middle _____ Goes By _____

Spouse Last _____ First _____ Middle _____ Goes By _____

Social Security Number _____ Birthdate _____ Age _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Employer _____ Spouse Employer _____

Home Phone _____ *Preferred contact number:* ☐ Cell ☐ Home ☐ Work

Work Phone _____ Email _____

Cell Phone _____ *May we confirm your appointment by email?* ☐ Yes ☐ No

Sex: ☐ Male ☐ Female *Text ok?* ☐ *Yes* ☐ *No*

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Whom can we thank for referring you to us today? _____

RESPONSIBLE PARTY

*If Patient is a Child, complete this section. Otherwise, skip to "**Dental Insurance**."*

Relationship to Patient: ☐ Mother ☐ Father ☐ Grandparent ☐ Other: _____

Last Name _____ First _____ Middle _____ Goes By _____

Spouse Last _____ First _____ Middle _____ Goes By _____

Social Security Number _____ Birthdate _____ Age _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Employer _____ Spouse Employer _____

Cell Phone _____ *Preferred contact number:* ☐ Cell ☐ Home ☐ Work

Home Phone _____ Email _____

Work Phone _____ *May we confirm your appointment by email?* ..... ☐ Yes ☐ No

DENTAL INSURANCE

	Primary	Secondary
Name of Subscriber:		
Relationship to Patient:		
Subscriber SSN or ID#:		
Subscriber Date of Birth:		
Insurance Company:		
Group & Policy Holder ID #:		
Employer:		

Do we have permission to contact your insurance company? ☐ Yes ☐ No

PAYMENT TODAY: ☐ Cash ☐ Check ☐ Visa/MC ☐ Care Credit ☐ Other:

By signing below, I acknowledge that the foregoing information I have provided is true and accurate. I agree that I will notify Tennessee Valley Endodontics at subsequent appointments if there are any changes in my information; for example, a change in phone number, address, or insurance.

Signature of **PATIENT** or **GUARDIAN** _____ **DATE** ___/___/___

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ENDODONTICS

MEDICAL HISTORY

Patient Name _____ **Date of Birth**____/____/____

Although endodontic personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you are taking, could have an important interrelationship with the dental care you will receive. Thank you for answering the following questions to the best of your knowledge.

Are you under a physician's care now?..... ☐ Yes ☐ No.....If yes, please explain: _____

Have you ever been hospitalized or had a major operation?.....☐ Yes ☐ No.....If yes, please explain: _____

Have you ever had a serious head or neck injury? ..... ☐ Yes ☐ No.....If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? .....☐ Yes ☐ No.....If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel
or any other medications containing bisphosphonates? ..... ☐ Yes ☐ No.....If yes, please explain: _____

Are you on a special diet? ..... ☐ Yes ☐ No.....If yes, please explain: _____

Do you use tobacco? ..... ☐ Yes ☐ No.....If yes, type/frequency: _____

Do you use controlled substances? ..... ☐ Yes ☐ No.....If yes, please explain: _____

Women Only Are you: ☐ Pregnant/Trying to Become Pregnant? ☐ Nursing ☐ Taking Oral Contraceptives?

Please mark all for which you have an **ALLERGY**: ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Aspirin ☐Local Anesthetics ☐Sulfa Drugs ☐Other:_____

Do you now have, or have you ever had, any of the following? *Please mark an X in the box of all that apply:*

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heartbeat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Low Blood Pressure	☐ Spina Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach/intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapsed	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness(es) not listed above? If yes, please explain: _____

Current Medications (*please list all*)	**Dosage and Frequency**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of **PATIENT** or **GUARDIAN** _____ **DATE**__/__/__

Tennessee Valley
ENDODONTICS

Barton T. Barrett, DMD

Cancelation and Rescheduling Policy

Thank you for choosing Tennessee Valley Endodontics for your dental care. We strive to provide the best service to all of our patients, and as such, we ask that all patients kindly provide us with a minimum of 24 hours notice to cancel or reschedule an appointment. We understand that emergencies occur, and we ask that if you cannot come to your appointment to please call us at 256-513-6888 to inform us.

As part of our cancellation and rescheduling policy, we require a minimum of 24 hours notice to cancel or reschedule an appointment. If we receive a cancellation with less than 24 hours' notice, prepayment for any necessary treatment will be required BEFORE scheduling another appointment.

Additionally, if another appointment is broken or rescheduled without adequate notice, a cancellation fee of $50 will be applied to your account, and the remainder of the pre-paid fee will be refunded by check to your home address. In such cases, we may also ask that you seek dental care elsewhere.

Please be advised that CONFIRMING your dental appointment with at least 24 hours' notice is a REQUIREMENT, due to the high volume of patients in need of root canal treatment at this time. Your prompt confirmation is essential for our scheduling and administrative purposes. If your appointment is not confirmed 24 hours prior, it will be assumed that you are unable to keep the appointment time and the appointment will be cancelled.

This policy is in place to protect our patients and to ensure that each patient receives his or her endodontic care in a timely manner . If you have any questions regarding this policy, please ask any of our staff prior to signing this form. If you require additional information or wish to file a complaint, you can find the information on how to do so below. Thank you.

Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your dental care, you may contact the Privacy Officer at:

Tennessee Valley Endodontics
Barton T. Barrett, DMD
100A Providence Main St. NW
Suite C
Huntsville, AL 35806
T: 256-513-6888
F: 256-513-6887

Your signature below is an acknowledgment that you have received and reviewed this Cancelation and Rescheduling Policy.

Signature: _____ Date: ____/____/____

Print Name: _____

Tennessee Valley
ENDODONTICS

Financial Agreement

Thank you for choosing Tennessee Valley Endodontics for your dental needs. We provide a variety of payment options to help you receive the dental care you deserve. The purpose of this financial policy is to eliminate any confusion concerning financial arrangements offered by our office. We communicate this policy to each patient.

For patients with insurance benefits, Tennessee Valley Endodontics will gladly prepare and submit dental insurance claims on your behalf. However, please note that reimbursements will be made directly to you by your insurance company. Since dental insurance companies do not share specific details about each patient's coverage with us, Tennessee Valley Endodontics cannot estimate your coverage or guarantee payment. For any questions about your dental benefits, please contact your insurance company directly.

The **full cost** of treatment is expected at the time of service. Treatment will continue only after financial arrangements have been made. The patient is responsible for all charges for dental services.

Payment options include **Cash, Check, Visa, MasterCard, American Express, Discover, and Care Credit.**

If I need financing for any portion of my balance, I understand that CareCredit is available. I am responsible for arranging financing through CareCredit before treatment. Tennessee Valley Endodontics does not offer in-house financing.

My signature acknowledges that I have read, understand and agree to the account payment and collection policies of Tennessee Valley Endodontics covered in this Financial Agreement.

By signing below, I authorize Tennessee Valley Endodontics to submit insurance claims on my behalf. I understand that Tennessee Valley Endodontics is not responsible for determining my insurance coverage or guaranteeing payment. In the event of a default, I agree to pay applicable interest on the outstanding balance, along with any collection costs, collection agency fees, and reasonable attorney fees necessary to collect the balance.

Signature: _____ Date: _____

Print Name: _____

BARTON T. BARRETT, D.M.D. | 256-513-6888 | TN-VALLEYENDO.COM
100A PROVIDENCE MAIN STREET NW., SUITE C HUNTSVILLE, AL 35806

Tennessee Valley
ENDODONTICS

Barton T. Barrett, DMD

Consent for Endodontic (Root Canal) Therapy

1. The purpose of root canal therapy is to retain a tooth that would otherwise require extraction.

2. Treatment will require the use of anesthetics, a series of diagnostic radiographs (x-rays), and may require multiple visits/appointments. *Please Note: Dr. Barrett will not be responsible for complications resulting from incomplete treatment if the patient fails to have treatment completed within two months of treatment start date.

3. In most cases, there is only a mild discomfort after treatment. This discomfort can usually be controlled with Tylenol©, Motrin©, or other prescribed medications.

4. Endodontic Treatment has a high degree of success (approx. 80-95%), but as with any medical or dental treatment, there is no guarantee of success or outcome. Occasionally, a tooth which has had root canal therapy may require retreatment, surgery, or even extraction.

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

6. The most common complications with root canal therapy include, but are not limited to:

   - Continued infection requiring endodontic surgery or extraction of the tooth.
   - Calcified (narrowed) canals or canals blocked by separated instruments requiring root canal surgery or extraction of the tooth.
   - Pain requiring the use of medications.
   - Side effects and possible reactions to medications.
   - Fracture of the root or crown of the tooth during or after treatment. It is recommended that all posterior (back) teeth be crowned after root canal treatment. If the tooth already has a crown, there is a chance it will need to be replaced due to decay or loss of structural support. Also, porcelain crowns are subject to breakage.
   - 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

7. Other treatment choices include: no treatment, waiting for definite development of symptoms, or a tooth extraction. Risks involved with these choices may include: pain, infection, swelling, loss of teeth, and possible infection in other areas.

8. If you have any questions please ask prior to signing this form or proceeding with your treatment.

I have read and understand the above information, understand the possible risks involved, and hereby consent to treatment.

Signature: _____ Date: ____/____/____

Tennessee Valley
ENDODONTICS

Barton T. Barrett, DMD

Notice of Privacy Practices

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.

Tennessee Valley Endodontics is required by law to maintain the privacy of your protected health information (PHI) and to provide individuals with notice of its legal duties and privacy practices currently in effect with respect to PHI. This Notice describes how we may use and disclose your PHI for treatment, payment, and for health care operations as well as for other purposes that are permitted or required by law. 45 CFR § 164.520.

Tennessee Valley Endodontics reserves the right to change the terms of this Notice and make the new notice provisions effective for all the PHI we maintain. If Practice makes a material change to this Notice, we will post the changes promptly. A paper copy of this Notice is available upon request.

Effective Date

This Notice of Privacy Practices became effective on April 14, 2003 and was amended on September 21st, 2011.

Types of Uses and Disclosures of your PHI

"Treatment" - We will use and disclose your PHI to provide, coordinate or manage your dental health care and any related services. We will also disclose PHI to other providers who may be treating you such as a specialist.

"Payment" - We will use your PHI to obtain payment for the dental health care services provided. For example, we may provide information to a health insurance company or business associate to obtain payment for the treatment provided for you.

"Healthcare Operations" -We will use your PHI to support the management of our dental office. For example, we may use information about you to conduct quality performance reviews regarding our services or the performance of our staff. Additionally, we may obtain services from business associates such as training programs, legal services and insurance.

HITECH Amendments

HITECH Act Breach Notification Requirements: The HITECH Act requires us to notify each individual whose unsecured PHI has been, or is reasonably believed to have been accessed, acquired or disclosed due to a breach. The HITECH Act imposes a similar requirement on Business Associates. "Unsecured PHI" refers to PHI that is not secured through the use of technologies or methodologies that render the PHI unusable, unreadable, or indecipherable to unauthorized individuals.

Restriction of Disclosure: The HITECH Acts restricts us from refusing an individual's request not to use or disclose the individual's PHI in instances where the patient's services were paid out of pocket to prevent the information from flowing to the health plan since no claim is being made against the third party payer.

Access to Electronic Health Records (EHRs): The HITECH Act expands the right of records access. Individuals have the right to access their EHR in an electronic format and to direct us to send the e-record directly to a third party. We may only charge for the labor costs to transfer this information.

Expansion of Accounting of Disclosures: The HITECH Act removed the accounting of disclosures exception of PHI to carry out treatment, payment and healthcare operations. All such disclosures must be accounted for if the disclosure is made through an EHR. We also will provide the individual with a list and contact information for all relevant business associates to obtain an accounting of disclosures of PHI.

Prohibition on Sale of PHI: The HITECH Act prohibits covered entities and business associates from receiving indirect or direct remuneration in exchange for PHI without obtain an authorization from the individual unless such an exchange meets one o f the exceptions listed by the government.

Responsibilities

Certain Uses or Disclosures: We will use and disclose your PHI when required to by federal, state or local law.

Appointment Reminders: We may contact you to provide appointment reminders via telephone or post cards. We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Revocation: Other uses and disclosures will be made only with your written authorization and you may revoke such authorization.

Public Health & Safety: We will use and disclose your PHI to public health authorities permitted to collect or receive information for the purpose of controlling disease, injury or disability.

Individual Rights

Request Restriction of Disclosures: You have the right to request restrictions on certain uses and disclosures of PHI and under HIPAA, Tennessee Valley Endodontics is not required to agree to the restriction unless as clarified by defined by the HITECH Act.

Right to Receive Confidential **Communications:** You have the right to receive confidential communications. Please specify your preference of communication in writing to us such as your home telephone, work telephone, mobile telephone, and / or email. We may provide relevant portions of your PHI to a family member, relative, close friend or any other person you identify as being involved in your dental care or payment.

Right to PHI: You have the right to inspect and copy the PHI that we maintain about you in our designated record set for as long as we maintain the information. We may charge a fee for the costs of copying, mailing or other supplies used in fulfilling your request. Please contact the Privacy Officer to inspect your record or receive a copy.

Right to Amend: You have the right to request that we amend your health information if you feel it is incomplete or inaccurate. You must make the request in writing to our Privacy Officer stating the reasoning that supports your request. We may deny the request if the information was not created by our office or if the person who created it is no longer available to make this amendment.

Right to Accounting: You have the right to receive an accounting of disclosures of your health information as required by law. Please submit a written request to our Privacy Officer.

Right to Paper Copy: You have a right to obtain a paper copy of the Notice of Privacy Practices.

Request Information or File a Complaint

If you have questions, would like additional information or want to report a problem regarding the handling of your PHI, you may contact the Privacy Officer at:

Tennessee Valley Endodontics
Barton T. Barrett, DMD
100A Providence Main St. NW
Suite C
Huntsville, AL 35806
T: 256-513-6888
F: 256-513-6887

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our Practice. You may also file a complaint with the Secretary of Health and Human Services at:

U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Room 515 FHHH Building
Washington, D.C. 20201
www.hhs.gov/ocr

Your signature below is an acknowledgment that you have received and reviewed this Notice of our Privacy Practices.

Signature:_____Date: ____/____/____

Print Name: _____

Tennessee Valley
ENDODONTICS

Release of Information

I authorize Tennessee Valley Endodontics to discuss my dental treatment, appointment information, insurance, and/or financial matters with the family member(s), spouse, caregiver(s), or friend(s) listed below.

Note: We routinely communicate with your referring dentist regarding your treatment, so there is no need to list your referring doctor on this form.

If there is **no one** you wish for us to discuss your information with, you may leave this section blank. However, your signature below is still required to acknowledge your preference.

_____ _____

Name *Relationship to Patient*

_____ _____

Name *Relationship to Patient*

**** _____ _____

PATIENT SIGNATURE *Date*