SHIPP ENDODONTICS
RYAN C. SHIPP DMD, MS
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INFORMATION AND CONSENT FORM

REGARDING HEALTH HISTORY, ENDODONTIC (ROOT CANAL) THERAPY, REMEDICATION, LOCAL ANESTHETIC AND MEDICATION: It is the belief of this office that you should be informed about the treatment (therapy) & that you should give your consent before starting that treatment. The purpose of this form is to tell of the risks that may occur in the endodontic (root canal) treatment, and other treatment choices.
Root canal treatment is done in order to retain a tooth (or teeth) which otherwise might need to be removed. Related dental surgery is done when needed. Risks of treatment are of two kinds: those risks involved in general dental procedures, & those risks specific to endodontic treatment.

RISKS OF DENTAL PROCEDURES IN GENERAL: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, sedation, medication, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth, thrombophlebitis (inflammation to the vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of the teeth or restoration in teeth, injury to other tissues, referred pain to the ear, neck and head, nausea, vomiting, allergic reactions, itching, bruises, delayed healing, sinus complications, and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous devise, or work for twenty-four hours or until recovered from their effects.

RISKS MORE SPECIFIC TO ENDODONTIC THERAPY: These risks include instruments broken within the root canals, perforations (extra openings) 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 dental surgery. These complications may include: blocked canals due to fillings, prior treatment, natural calcifications, broken instruments, curved roots, periodontal disease (gum disease), and fractures of the teeth.

THE OTHER TREATMENT CHOICES INCLUDE: No treatment, waiting for more definite development of symptoms or having the tooth removed. Risks involved in these choices might include pain, swelling, infection, loss of tooth and infection to other areas. Treatment will be done in a manner to minimize or avoid risks, but success cannot be guaranteed. Although root canal therapy has a high degree of success, it cannot be guaranteed. Occasionally a tooth which has had root canal therapy may require retreatment, surgery or even extraction.

When the endodontic therapy is completed your tooth will require a permanent restoration. Our fee does not include this procedure. **Your referring dentist will render this service which is mandatory for the preservation of your tooth**. Please make an appointment with your dentist within two weeks after being discharged by our office.

I understand that upon my request I may receive a copy of this form. I, the undersigned, being the patient (parent or guardian of minor patient) consent to the performing of the procedures that are determined to be necessary or advisable.

Patient/Guardian Signature_____Date_____

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Notice of Privacy Practices

Protecting Your Confidential Health Information is important to Us

Dear Patient,

It is our desire to communicate to you that we are taking the new Federal (HIPPAA-Health Insurance Portability and Accountability Act) laws written to protect the confidentiality of your health information seriously. We do not ever want to delay treatment because you are afraid your personal heath history might be unnecessarily made available to others outside of our office.

We will use and communicate your health information only for the purposes of providing your treatment. Obtaining payment and conducting health care operations. Your health information will not be used for other purposes unless we have asked for and been voluntarily given your written permission.

How your health information may be used

To Provide Treatment:
We will use your health information within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimized scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentist, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment.

To Obtain Payment:
We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with similar commitment to the security of your health information.

To Conduct Health Care Operations:
Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patient receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies and government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during routine processes of certification, licensing or credentialing activities.

In Patient Reminders:
Because we believe regular care is important to your oral and general health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you of treatment options or services.

These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best preventative and restorative care modern dentistry can provide. They may include post cards, folding, post cards, letters, telephone reminders, or electronic reminders such as email (unless you tell us you do not want to receive these reminders).

Abuse or Neglect:
We will notify government authorities if we believe a patient is a victim of abuse, neglect, or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Public Health and National Security:
We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement:

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers:
We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

Authorization to Use or Disclose Health Information:
Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Restrictions:
You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restrictions preferences from our patients.

Confidential Communications:
You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information:
You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information please let us know. We may charge you a reasonable fee to duplicate and assemble your copy.

Amend Your Health Information:
You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change. Your request may be denied if the health information record in question was not created by our office, is not a part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information:
You have the right to ask for a description of how and where your health information was used by our office for any reason other than for treatment, payment, or health operations. Our documentation procedures will enable us to provide information on your health information usage. Please let us know in writing the time period for which you are interested. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice:
You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

We are required by law to maintain the privacy of your health information and to provide you and your representative this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice, but we reserve the right to change the terms of our notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised notice. *You have the right* to express complaints to us or the secretary of Health and Human Services if you believe you privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns or complaints in writing.

Patient Acknowledgment

Patient Name: _____

Patient Signature: _____ Date: _____

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Personal and Health History

Please Print

Patient's Name:_____ Date of Birth:_____ Sex: M or F

Email (required for billing purposes):_____

Home Address:_____ Zip:_____

Phone #:_____ Soc.Sec #(required) :_____

Employer:_____Address:_____

Dental Insurance Carrier:_____

Spouse employer (if the insured)_____ Spouse Date of Birth:_____

Spouse/Parent Name:_____Phone: _____

Who is your General Dentist:_____

Preferred Pharmacy Name and Address:_____

Please check those that apply

- ☐ Hypertension
- ☐ Pregnant Wk_____
- ☐ Respiratory/Asthma
- ☐ Rheumatic Fever
- ☐ HIV
- ☐ Anemia/Bleeding
- ☐ Diabetes/Kidney
- ☐ Herpes
- ☐ Thyroid
- ☐ Hypoglycemia
- ☐ Shortness of Breath
- ☐ Cancer
- ☐ Radiation/Chemo
- ☐ Tuberculosis
- ☐ Ulcers/Digestive
- ☐ Migraines/Headaches
- ☐ Epilepsy/Fainting
- ☐ Glaucoma/Visual
- ☐ Mental/Neural
- ☐ Tumor/Neoplasm
- ☐ Drug Addictions
- ☐ Infectious Diseases
- ☐ Psychiatric care
- ☐ TMJ
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Defect
- ☐ Pacemaker
- ☐ Heart Attack
- ☐ Stroke
- ☐ Joint Replacement
- ☐ Arthritis
- ☐ Other

Allergies

- ☐ None
- ☐ Penicillin
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Tylenol
- ☐ Codeine
- ☐ Narcotics
- ☐ Local Anesthetic
- ☐ Latex
- ☐ Valium/Tranquil.
- ☐ Nitrous
- ☐ Food Allergy
- ☐ Bleach
- ☐ Iodine/Seafood
- ☐ Other

Current Meds

- ☐ None
- ☐ Antibiotic
- ☐ Pain Meds
- ☐ Heart
- ☐ Aspirin
- ☐ Cortisone/ steroids
- ☐ Blood Thinner
- ☐ Blood Pressure
- ☐ Hormone
- ☐ Thyroid
- ☐ Birth Control
- ☐ Insulin
- ☐ Ulcer
- ☐ Bone Related
- ☐ Other

Any other Health Information:

Signature:_____Date_____

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INSURANCE and FINANCIAL POLICY

We are happy to help you with your insurance coverage as it relates to treatment needs in our office. Fees vary depending on the treatment required and are to be estimated and quoted in advance of treatment. If this has been neglected, please do not hesitate to ask. From the information provided by you and your insurance company, we will formulate an **ESTIMATE** of what you will need to pay "out of pocket" for your treatment. Keep in mind that the entire bill is **YOUR** responsibility regardless of what the insurance company pays.

When your insurance company pays for services provided, the actual covered amount may be different from what was estimated. Any overpayment's will be refunded, and any amounts underpaid will be your responsibility. If for any reason the insurance company denies the entire claim, you will be responsible for payment of any services provided. When the endodontic therapy is completed your tooth will require a permanent restoration. Our fee does not include this procedure.

Payment is due at the time of service. If you have dental insurance your estimated co-pay will be collected the day of treatment. In the event of a balance due, payment is not to exceed 30 days from mailing of a billing statement. In the event of a late payment or any dispute arising regarding payments due, you agree to pay all costs and attorney's fees incurred for collections. You also acknowledge and agree that in the event you do not pay in full for services rendered, your account may be placed with a collection agency. Per NRS 649.375(2)(b), a collection fee of 50% will be added to your balance, and reasonable attorney fees, and court cost incurred in the collection of an overdue account.

Patient name (Please print) _____

Patient/Guardian Signature_____ Date_____

SHIPP
ENDODONTICS

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INFORMED CONSENT FOR
CONTROLLED SUBSTANCE THERAPY FOR PAIN

In Nevada, per Assembly Bill 474, prescriber's must inform their patients of information regarding the treatment of pain with the use of a controlled substance. **If you are prescribed a controlled substance you consent to the following. Please review the information listed here and initial each item below:**

_____ I understand there are non-opioid alternative means of treatment for my symptoms, including but not limited to Aspirin, Naproxen (Aleve), Ibuprofen (Motrin or Advil), or Acetaminophen (Tylenol).

_____ I understand that I may be prescribed medications, including controlled substances, for the treatment of pain. 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). I understand that when I take controlled substances(s), I may experience certain reactions for 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 if any of these symptoms should occur, I should discontinue taking the medication and consult with the providing doctor or my physician.

_____ 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 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 a high risk. I will notify 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 the reach of children or others that may be able to access them. To safely dispose of unused medications, I can return the unused medications in the bottle to a local pharmacy. I understand that I am not to dispose of unused medications into the toilet or sink.

_____ I understand that due to the risk of possible overdose resulting from 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 that may include over the counter pain management and/or controlled substances.

_____ _____ _____

Patient Name printed Patient Signature Date