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**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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## OUR LEGAL DUTY

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect 9/23/2013, 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, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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## HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment and health care operations. For each of these categories, we have provided a description and example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

- **Treatment:** We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment for you.
- **Payment:** We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management and determinations of eligibility and coverage to obtain payment from you, an insurance company or another third party. For example, we may send claims to your dental health plan containing certain health information.
- **Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs and licensing activities.
- **Individuals Involved in Your Care or Payment for Your Care:** We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health decisions for you, we will treat the patient representative the same way we would treat you with respect to your health information.
- **Disaster Relief:** We may use or disclose your health information to assist in disaster relief efforts.
- **Required by Law:** We may use or disclose your health information when we are required to do so by law.
- **Public Health Activities:** We may disclose your health information for public health activities, including disclosures to: Prevent or control disease, injury or disability; Report child abuse or neglect; Report reactions to medications or problems with products or devices; Notify a person of a recall, repair, or replacement of products or devices; Notify a person who may have been exposed to a disease or condition; Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.
- **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 the protected health information of an inmate or patient.
- **Security of HHS:** We will disclose your health information to the Secretary of the U.S Department of Health and Human Services when required to investigate or determine compliance with HIPPA.
- **Worker's Compensation:** We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
- **Law enforcement:** We may disclose you PHI for law enforcement purposes as permitted by HIPPA, as required by law, or in response to a subpoena or court order.
- **Health Oversight Activities:** We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Judicial and Administrative Proceedings:** If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.
- **Research:** We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.
- **Coroners, Medical Examiners and Funeral Directors:** We may release your PHI to a coroner or medical examiner. This may be necessary, for example to identify a deceased person or determine cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.
- **Fundraising:** We may contact you to provide you with information about our sponsored activities, including fundraising programs as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

**OTHER USES AND DISCLOSERS OF PHI:** Your authorization is required, with few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

**YOUR HEALTH INFORMATION RIGHTS:**

- **Access:** You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want the copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

- **Disclosure Accounting:** With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.
- **Right to Request a Restriction:** You have the right to request additional restrictions on our use or disclosure of you PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.**
- **Alternative Communications:** You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location your request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.
- **Amendment:** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why denied it and explain your rights.
- **Right to Notification of a Breach:** You will receive notifications of breaches of your unsecured protected health information as required by law.
- **Electronic Notice:** You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (email)

**QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us.

**If you are concerned that** we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternate locations, you may complain to us using the contact information listed at the end of this Notice. You also may 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 upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**CONTACT INFORMATION**

Our Privacy Official: Molly Owens  
 Telephone: (216)-485-5788  
 Address: 6700 West Snowville Road Brecksville, OH 44141  
 Email: [hipaa@crestdentalimplants.com](mailto:hipaa@crestdentalimplants.com)

	DDC Endodontics and Crest Dental Implants
Contact Person	Office Manager
Address	7081 Pearl Road Middleburgh Heights, OH 44130
Phone Number	216-282-1491

# Patient Health History

DATE: \_\_\_\_\_

## **Patient Information**

First: \_\_\_\_\_ Middle \_\_\_\_\_ Last: \_\_\_\_\_

Street: \_\_\_\_\_ Apt. # \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Patient Social Security #: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_ Sex: M F

\_\_\_Married \_\_\_Single \_\_\_Widowed \_\_\_Separated \_\_\_Divorced Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: Zip: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

If Student, name of School/College: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

How did you hear about us?

Insurance Provider   
  Television   
  Radio   
  Mailing   
  Social Media   
  Online Review  
 Internet   
  Community Event   
  Other   
  Referral   
 \_\_\_\_\_ (Patient Name)

**If the person responsible for this patient's account is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled "Insurance Information".**

Name of responsible party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex: M F Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Single Married Widowed Separated Divorced SS#: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## **Insurance Information**

### **Primary Dental Insurance**

Policy Holder's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_ State: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Group #: \_\_\_\_\_ Member ID #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

### **Secondary Dental Insurance**

Policy Holder's Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_ State: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ Group #: \_\_\_\_\_ Member ID #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

**HEALTH HISTORY**

Answers to the following questions are for our records only and will be considered confidential.

Place a mark, yes or no, to indicate if you have had any of the following:

Heart Disease or Attack	Yes	No	Shortness of Breath	Yes	No	Alcoholism	Yes	No
Angina Pectoris	Yes	No	Ulcers	Yes	No	Herpes	Yes	No
Heart Problems	Yes	No	Intellectual Disability	Yes	No	Glaucoma	Yes	No
Liver Disease	Yes	No	Emphysema	Yes	No	*Steroid Treatment	Yes	No
High Blood Pressure	Yes	No	Fainting or Dizzy Spells	Yes	No	Arthritis	Yes	No
*Heart Murmur	Yes	No	Epilepsy or Seizures	Yes	No	Birth Defects	Yes	No
*Rheumatic Fever	Yes	No	Persistent Cough	Yes	No	HIV Positive, ARC, AIDS	Yes	No
Psychiatric Treatment	Yes	No	Tuberculosis (TB)	Yes	No	Hay Fever	Yes	No
Sickle Cell Disease	Yes	No	Asthma	Yes	No	Use of Tobacco Products	Yes	No
Sinus Trouble	Yes	No	*Congenital Heart Problems	Yes	No	Bruise Easily	Yes	No
*Artificial Joints	Yes	No	Hepatitis A (Infectious)	Yes	No	Jaundice	Yes	No
Thyroid Disease	Yes	No	Hepatitis B (Serum)	Yes	No	Kidney Trouble	Yes	No
Anemia	Yes	No	Hepatitis C or Other	Yes	No	Human Papilloma Virus/HPV	Yes	No
Blood Transfusion	Yes	No	Heart Pacemaker	Yes	No	Hemophilia	Yes	No
*Any Type of Transplant	Yes	No	Stroke	Yes	No	Diabetes _____ Type I _____ Type II	Yes	No
*Mitral Valve Prolapse	Yes	No	Drug Addiction	Yes	No	Chemotherapy/Radiation	Yes	No
Hives or Skin Rash	Yes	No	Cold Sores	Yes	No	Cancer, type: _____	Yes	No
Scarlet Fever	Yes	No	COPD	Yes	No	MRSA	Yes	No

(Chronic Obstructive Pulmonary Disorder)

\*Antibiotic pre-medication may be required prior to your appointment.

**ALLERGIES**

Aspirin                      Local Anesthetic                      None  
 Barbituates                Penicillin  
 Codeine                      Sulfa  
 Iodine                        Metals  
 Latex                         Other: \_\_\_\_\_

**MEDICATIONS**

Please list medications you are currently taking:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Pharmacy: \_\_\_\_\_

Do you have existing dentures      Yes      No      How old is denture \_\_\_\_\_      Upper/Lower  
 Do you have existing partials      Yes      No      How old is partial \_\_\_\_\_      Upper/Lower

1. Have you or any member of your family been seen by us before?      Yes      No  
 If yes, which family member(s)? \_\_\_\_\_
2. Date of last physical examination: \_\_\_\_\_      Physician's name: \_\_\_\_\_
3. Previous dentist's name: \_\_\_\_\_      Date of last dental x-rays: \_\_\_\_\_
4. Are you having pain or discomfort at this time?      Yes      No
5. Do you clench or grind your teeth?      Yes      No
6. Do you have any sores, lumps or growths in or near your mouth?      Yes      No
7. Have you ever had any excessive bleeding requiring special treatment?      Yes      No
8. Have you ever needed to see a periodontist?      Yes      No
9. Is there anything you would like to change about the way your smile looks?       straighter       whiter
10. Do you currently have any of the following?       swelling       bleeding gums       loose teeth       bad breath
11. Have you experienced any reactions to treatment in your previous visits to the Dentist?      Yes      No  
 If yes, please explain: \_\_\_\_\_
12. Is there anything related to your medical or dental history that you have not indicated above?      Yes      No  
 If yes, please explain: \_\_\_\_\_

WOMEN: Are you pregnant now?      Yes      No      If yes, what is your due date? \_\_\_\_\_  
 Are you currently breast feeding?      Yes      No  
 Are you taking oral contraceptives?      Yes      No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

**X** \_\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_  
 Signature of Patient or Parent/Guardian      Print Name      Date

**X** \_\_\_\_\_      \_\_\_\_\_  
 Doctor Signature      Date

# Informed Consent



## All patients complete 1 through 4 below and 5 through 13 as needed

### **1. EXAMINATIONS AND X-RAYS**

I understand that the initial visit may require radiographs in order to complete the examination diagnosis and treatment plan. I understand I am to have work done as detailed in the attached treatment plan

(Initials\_\_\_\_\_)

### **2. DRUGS, MEDICATION, AND SEDATION**

I have been informed and understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the dentist of any known allergies. They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours or until fully recovered from the effects of the anesthetic, medications, and drugs that may have been given to me in the office for my care. I understand that failure to take medications prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills). I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking.

(Initials\_\_\_\_\_)

### **3. CHANGES IN TREATMENT PLAN**

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give permission to the dentist to make any/all changes and additions as necessary

(Initials\_\_\_\_\_)

### **4. TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)**

I understand that popping, clicking, locking, and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent in routine dental treatment wherein the mouth is held in the open position although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients. I understand that should the need for treatment arise then I will be referred to a specialist for treatment, the cost of which is my responsibility.

(Initials\_\_\_\_\_)

### **5. DENTAL PROPHYLAXIS (CLEANING)**

I understand the treatment is preventative in nature, intended for patients with healthy gums, and is limited to the removal of plaque and calculus from the tooth structures in the absence of periodontal (gum) disease.

(Initials\_\_\_\_\_)

### **6. FILLINGS**

I understand that a more expensive restoration than originally diagnosed may be required due to additional decay of unsupported tooth structure found during preparation. This may lead to other measures necessary to restore the tooth to normal function. This may include root canal, crown, or both. I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly-placed filling.

(Initials\_\_\_\_\_)

### **7. REMOVAL OF TEETH**

Alternatives to removal have been explained to me (root canal therapy, crown and periodontal surgery, etc.) and I authorize the dentist to remove the following teeth \_\_\_\_\_ and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, exposed sinuses, loss of feeling in my cheeks, lips, tongue, and surrounding tissue (Parasthesia) that can last for an indefinite period of time, or fractured jaw. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

(Initials\_\_\_\_\_)

### **8. CROWNS, BRIDGES, VENEERS, AND BONDING**

a. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize that the final opportunity to make changes in my new crown, bridge, or veneer (including shape, fit, size, and color) will be before cementation. It has been explained to me that in very few cases, cosmetic procedures may result in the need for future root canal treatment, which cannot always be predicted or anticipated. I understand that cosmetic procedures may affect tooth surfaces and may require modification of daily cleaning procedures. It is also my responsibility to return for permanent cementation within 20 days after tooth preparation. Excessive delays may allow for decay, tooth movement, gum disease, and/or bite problems. This may necessitate a remake of the crown, bridge, or veneer. I understand there will be additional charges for remakes or other treatment due to my delaying permanent cementation.

(Initials\_\_\_\_\_)

b. I am electing to use noble, high noble, or ceramic instead of base metal in my crown and bridge restorations.

(Initials\_\_\_\_\_)

c. I am electing to do a fixed bridge or implant replacement of missing teeth instead of a removable appliance. I understand that a fixed bridge or implant and crown may not be a covered benefit under my insurance policy.

(Initials\_\_\_\_\_)

**9. DENTURES – COMPLETE OR PARTIAL**

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing those appliances have been explained to me including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. Immediate dentures (placement of dentures immediately after extractions) may be uncomfortable at first. Immediate dentures may require several adjustments and relines. A permanent reline or a second set of dentures will be necessary later. This is not included in the initial denture fee. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee. I understand that it is my responsibility to return for delivery of dentures. I understand that failure to keep delivery appointments may result in poorly-fitted dentures. If a remake is required due to my delay of more than 30 days there will be additional charges.

(Initials \_\_\_\_\_)

**10. ENDODONTIC TREATMENT (ROOT CANAL)**

I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment and that occasionally, canal material may extend through the root tip which does not necessarily affect the success of the treatment. The tooth may be sensitive during treatment and even remain tender for a time after treatment. Hard to detect root fracture is one of the main reasons root canals fail. Since teeth with root canals are more brittle than other teeth, a crown is necessary to strengthen and preserve the tooth. I understand that endodontic files and reamers are very fine instruments and stresses can cause them to separate during the use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (Apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.

(Initials \_\_\_\_\_)

**11. PERIODONTAL TREATMENT**

I understand that I have a serious condition causing gum inflammation and/or bone loss, and that it can lead to the loss of my teeth and/or negative systemic conditions (including uncontrolled diabetes, heart disease, and pre-term labor, etc.) Alternative treatment plans have been explained to me, including non-surgical therapy, antibiotic/antimicrobial treatment, gum surgery, and/or extractions. I understand the success of any treatment depends in part on my efforts to brush and floss daily, receive regular therapeutic cleanings as directed, follow a healthy diet, avoid tobacco products, and follow other recommendations. I understand bleeding could last for several hours. Should it persist, particularly if it is severe in nature, it should receive attention and this office must be contacted. I understand that periodontal disease may have a future adverse effect on the long-term success of dental restoration work.

(Initials \_\_\_\_\_)

**12. IMPLANTS**

I understand that no dentistry is permanent and that ideal implant placement may not be possible based on anatomic limitations. I have been informed that there is always the possibility of failure resulting from the tissues of the body not physiologically accepting these artificial devices and infections may occur post operatively which may necessitate removal of the affected implant(s). I realize there is the slight possibility of injury to the nerves of the face and tissues of the oral cavity, and this numbness may be temporary or rarely permanent in nature. I understand that it is absolutely necessary with implant therapy to have regular periodic examinations and cleanings. I agree to assume the responsibility to make appointments and report as instructed by the treating dentist.

(Initials \_\_\_\_\_)

**13. BLEACHING**

Bleaching is a procedure done either in office (approximately 1 hour) or with take-home trays (several treatments over 2-4 weeks). The degree of whitening varies with the individual. The average patient achieves considerable change (1-3 shades on the dental shade guide). Coffee, tea, and tobacco will stain teeth after treatment and are to be avoided for at least 24 hours after treatment. I understand I may experience sensitivity of the teeth and/or gum inflammation, which may subside when treatment is discontinued. The dentist may prescribe fluoride treatments to aid with sensitivity. Carbamide peroxide and other peroxide solutions used in teeth bleaching are approved by the FDA as mouth antiseptics. Their use as bleaching agent has unknown risks. Acceptance of treatment means acceptance of risk. Pregnant women are advised to consult with their physician before starting treatment.

(Initials \_\_\_\_\_)

**14. NITROUS OXIDE**

I elect to have nitrous oxide in conjunction with my dental treatment. I have been informed and understand the possible side effects that may occur. These include, but are not limited to, nausea, vomiting, dizziness, and headache. I understand that nitrous oxide use is not indicated if I am pregnant.

(Initials \_\_\_\_\_)

**15. DENTAL BENEFITS**

I understand that my insurance may provide only the minimum standard of care. I understand that submitting insurance and receiving a benefit is my responsibility. I elect to follow the dentist's recommendation of optimal dental treatment.

(Initials \_\_\_\_\_)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment I have requested and authorized. I understand that each dentist is an individual practitioner and is individually responsible for the dental care rendered to me. I also understand that no other dentist or corporate entity, other than the treating dentist, is responsible for my dental treatment. I acknowledge the receipt of and understand post-operative instructions and have been given an appointment date to return.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Doctor: \_\_\_\_\_

Date: \_\_\_\_\_

## Informed Consent Cone Beam CT Scan

**1. A CBCT Scan, also known as Cone Beam Computerized Tomography,** is an x-ray technique that produces 3D images of your skull that allows visualization of internal bony structures in cross section rather than as overlapping images typically produced by conventional x-ray exams. CBCT scans are primarily used to visualize bony structures, such as teeth and your jaws, not soft tissue such as your tongue or gums.

**2. Advantages of a CBCT Scan over conventional X-rays:** A conventional x-ray of your mouth limits your dentist to a two-dimensional or 2D visualization. Diagnosis and treatment planning can require a more complete understanding of complex three-dimensional or 3D anatomy. CBCT examinations provide a wealth of 3D information which may be used when planning for dental implants, surgical extractions, maxillofacial surgery, and advanced dental restorative procedures. Benefits of CBCT scans include: A. Higher accuracy when planning implant placement surgery; B. Greater chance for diagnosing conditions such as vertical root fractures that can be missed on conventional x-ray films; C. Greater chance of providing images and information which may result in the patient avoiding unnecessary dental treatment; D. Better diagnosis of third molar (wisdom teeth) positioning in proximity to vital structures such as nerves and blood vessels prior to removal; E. The CBCT scan enhances your dentist's ability to see what needs to be done before treatment is started.

**3. Radiation:** CBCT scans, like conventional x-rays, expose you to radiation. In the office of **Dr. Peter Amin**, the dose of radiation used for CBCT examinations is carefully controlled to ensure the smallest possible amount is used that will still give a useful result. The dosage per scan is equivalent to 2 regular dental x-rays. However, all radiation exposure is linked with a slightly higher risk of developing cancer. But the advantages of the CBCT scan outweigh this disadvantage.

**4. Pregnancy:** Women who are pregnant should not undergo a CBCT scan due to the potential danger to the fetus. Please tell the dentist if you are pregnant or planning to become pregnant.

**5. Diagnosis of non-dental conditions:** While parts of your anatomy beyond your mouth and jaw may be evident from the scan, your dentist may not be qualified to diagnose conditions that may be present in those areas. If any abnormalities, asymmetries, or common pathologic conditions are noted upon the CBCT scan, it may become necessary to send the scan to an Oral and Maxillofacial Radiologist for further diagnosis. However, by signing this form, you are acknowledging that your dentist may not be qualified to diagnose all conditions that may be present, and that his/her liability only extends to the limits of the dental purpose of the scan and its interpretation for that purpose. **We are not responsible for interpretation or evaluation of the scan, but are only providing the scan for the evaluation at your dental office.**

**PLEASE DO NOT SIGN THIS FORM UNLESS YOU HAVE READ IT, UNDERSTAND IT, AND AGREE TO ACCEPT THE RISKS AND ADVANGAGES NOTED.**

I, \_\_\_\_\_ being 18 years or older, certify that I have read the above statement. I understand the procedure to be used and its benefits, risks, and alternatives. I have been given the opportunity to have my questions answered, and accept the risks of the CBCT scanning procedure as described above. I therefore give my consent to have **the DDC Endodontics and Cresta Dental Implants** staff, as they may designate, perform a CBCT scan.

Signature of Patient, or Legal Guardian \_\_\_\_\_ Date: \_\_\_\_\_

Witness to Signature \_\_\_\_\_ Date: \_\_\_\_\_



## FINANCIAL POLICY NOTICE AND DISCLAIMER

At DDC Endodontics and Cresta Dental Implants, we are committed to providing all our patients with the best possible care and service. It's important to us that you have a clear understanding of our financial policies. If you have any questions, please ask any staff member for clarification. Thank you for choosing DDC Endodontics and Cresta Dental Implants.

### Personal Payments

Patients are responsible for their charges at the time the service is provided. We accept major credit/debit cards (Visa, Master Card, Discover, Amex) and checks with personal identification.

### Patients with Insurance Coverage

Please understand that your insurance coverage is based on a contract between you and your insurance company. The ultimate responsibility for payment always rests with the patient. As a courtesy, we will bill your insurance company for its share of the charges you incur **if current and correct information is provided**. Your share of the bill (your co-pay) is due at the time of service. Please be aware that any bill we send to your insurance company is an estimate only. ***You are ultimately responsible for any portion of your bill not covered by your insurance.*** In the event that your insurance company determines that any service you received is "not covered", you are responsible for the **complete fee**. If your insurance company denies, makes less than full payment, or takes more than 45 days to remit payment, you are responsible for the entire balance.

### Financing Options

We are happy to offer our patients, upon application approval, a monthly payment plan through **Care Credit**. There are several interest-free payment plans to choose from and some extended payment plans with small interest rates offered as well. Please feel free to request more information about this option.

### Minor Patients and Legal Settlements

DDC Endodontics and Cresta Dental Implants is not party to any legal settlement resulting from a divorce or child support arrangement. Adult patients are responsible for payment at the time service is provided. Responsibility for minors rests with the adult accompanying the patient at the time treatment is provided. Payment for services rendered to a minor is the responsibility of the adult accompanying the patient. A parent or legal guardian should be present to sign a treatment consent form for all patients under the age of 18.

### Additional Information

There will be an additional charge of \$30 for each invalid or NSF check. Any NSF account remaining unpaid after 10 days will be turned over to collections. Any account remaining unpaid after 30 days may be charged interest at a rate not to exceed that allowed by the state of Ohio. Any account remaining unpaid for over 60 days for which a payment plan has not been arranged or for which scheduled payments are delinquent may be turned over to a collection agency. If an account has been turned over to a collection agency, the patient is responsible for any additional fees incurred in the collection process. In the event a refund is due, payment will be given within 2 weeks after the amount is verified by DDC Endodontics and Cresta Dental Implants. Payment will be rendered in the form in which it was originally submitted (if received in cash, then payment will be rendered in the form of a check). There will be a 5% processing fee deducted for refund requests to issue a check refund for payments initially made with a credit card. Unopened products can be returned in their original packaging within 15 days of purchase.

### CANCELLATION POLICY

We know how valuable your time is and will do our very best to see you at the time of your scheduled appointment. However, if you fail to show up, we could have been providing service to another, equaling deserving patient. **We reserve the right to reschedule your appointment or decrease designated appointment time if you arrive late. A \$50.00 "Failed Appointment" fee may be charged if our office is not informed with advance notice of 48 hours or more. If you miss more than 2 appointments without prior notice, we may regrettably have to refer you to another practice for your oral care.** Any courtesy discounts are subject to cancellation if you do not comply with DDC Endodontics and Cresta Dental Implants' cancellation policy.





**INSURANCE ASSIGNMENT & RELEASE**

Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, we urge you, as the patient, to please check with your insurance company PRIOR to any treatment being performed. Please remember your insurance policy is between you and your insurance company.

**INITIAL HERE THAT YOU HAVE READ THE ABOVE**

- \_\_\_ I AUTHORIZE USE OF THIS FORM ON ALL MY INSURANCE SUBMISSIONS.
- \_\_\_ I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE CARRIERS.
- \_\_\_ I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL.
- \_\_\_ I AUTHORIZE MY DOCTOR TO ACT AS AN AGENT IN HELPING ME OBTAIN PAYMENT FROM MY INSURANCE CARRIERS.
- \_\_\_ I AUTHORIZE PAYMENT DIRECTLY TO MY DOCTOR.
- \_\_\_ I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.
- \_\_\_ I UNDERSTAND THAT EVEN THOUGH THIS OFFICE IS ACTING AS AN AGENT BETWEEN ME AND MY INSURANCE COMPANY, THE INSURANCE POLICY BELONGS TO ME AND I AM RESPONSIBLE FOR WHATEVER THE INSURANCE COMPANY DOES NOT PAY.

I certify that I and/or my dependent(s) have insurance coverage with \_\_\_\_\_ and assign directly to DDC Endodontics and Cresta Dental Implants all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize DDC Endodontics and Cresta Dental Implants to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I also authorize the use of this signature to furnish all medical records pertaining to treatment of patient.

Name (please print) \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_  
(Parent or Guardian must sign if patient is a minor)

**Financial Policy Notice and Disclaimer**

I acknowledge that I have read, understand and agree to DDC Endodontics and Cresta Dental Implant’s Financial Policy Notice

\_\_\_\_\_  
Patient Initials

**HIPAA Privacy Sheet**

I acknowledge that I have received a copy of the HIPAA privacy sheet

\_\_\_\_\_  
Patient Initials



## APPOINTMENT CONTRACT

Your appointment is time that has been set aside for you with your provider. It is your responsibility to maintain and attend all scheduled appointments.

If for any reason you need to change an appointment, it is your responsibility to contact the office at least 48 hours prior to that appointment.

Our doctors want to be available for your needs and the needs of all patients. When a patient does not show up for a scheduled appointment another patient loses the opportunity to be seen.

Please be advised that the policy of DDC Endodontics and Cresta Dental Implants to **dismiss** any patient, who fails to show up for three scheduled appointments. In the event that DDC Endodontics and Cresta Dental Implants finds it necessary to dismiss you as a patient, a letter will be mailed to you.

I acknowledge that I have read the above and understand the consequences and my responsibilities.

Name (please print) \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_

(Parent or Guardian must sign if patient is a minor)