Steve Osmond, DDS, MSD
Practice Limited to Endodontics

Medford Endodontics
831 Alder Creek Dr, Medford, OR 97504
(541) 776-7640 · medfordrootcanal@gmail.com

PATIENT INFORMATION

Patient Information

Name _____ Birthdate _____ Social Security # _____

Physical Address _____ Apt/Space _____

City _____ State _____ Zip Code _____

Mailing address if different than physical address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____

Spouse's Name _____ Work Phone _____ Ext _____ Cell _____

Referring Dentist _____ Emergency Contact _____

Primary Dental Insurance *(unless you have a current dental insurance card)*

Subscriber Name _____ Subscriber Birthday _____ Subscriber SS # _____

Subscriber Employer _____ Policy/Member ID # _____

Insurance Co. Name _____

Insurance Co. Address _____ City _____ State _____ Zip Code _____

Secondary Dental Insurance *(if applicable)*

Subscriber Name _____ Subscriber Birthday _____ Subscriber SS # _____

Subscriber Employer _____ Policy/Member ID # _____

Insurance Co. Name _____

Insurance Co. Address _____ City _____ State _____ Zip Code _____

Responsible Party *(if not the same as patient)*

Name _____ Relationship to patient _____

Birthdate _____ Phone _____ Work Phone _____

Social Security # _____ Address _____ City _____ Zip _____

Payment is due in full at the time of treatment. We will provide assistance to aid you in obtaining insurance reimbursement; however, you are responsible for all costs of dental treatment. *Your portion is just an estimate and may be lower or higher depending on your insurance fee schedule.* If you want to know exact amount of portion, we can submit a pre-authorization which takes about 3-6 weeks. I understand that I am responsible for all costs of dental treatment. A finance charge will be added to accounts over 30 days past due. Accounts that become delinquent and sent to collections will be assessed a $25 processing fee to be forwarded to collections. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____ _____

Patient or Guardian Signature Date

PLEASE CONTINUE FILLING OUT THE REMAINING FORMS ATTACHED

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HEALTH HISTORY

Name _____ **Birthdate** _____

Preferred pharmacy and location _____

My Medical Physician is Dr. _____ Phone No. _____

Are you nervous about having dental treatment? ☐ Yes ☐ No

Have you been under the care of a medical doctor in the last 2 years other than normal routine visits? ☐ Yes ☐ No

Have you been a patient in a hospital in the last 2 years? If yes then reason _____ ☐ Yes ☐ No

Have you ever taken medication for osteoporosis or for bone treatment (Fosamax, Zometa, Boniva, Aredia, Actonel, Skelid, Bonefos, Ostac, Didronel, or any other bisphosphonate)? ☐ Yes ☐ No

Has your physician said you need antibiotics or pre-medication 1 hour before dental treatment? (Artificial Joint) ☐ Yes ☐ No

Have you **ever** had any of the following:

High blood pressure	☐ Yes ☐ No	Sinus problems	☐ Yes ☐ No	Epilepsy/Seizures	☐ Yes ☐ No
Heart attack	☐ Yes ☐ No	Respiratory problems	☐ Yes ☐ No	Nervous disorder	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Blood disorder/Anemia	☐ Yes ☐ No
Arrhythmias	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Abnormal bleeding	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Blood transfusion	☐ Yes ☐ No
Rheumatic fever	☐ Yes ☐ No	Liver disorder	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Heart murmur	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No	AIDS/HIV-positive	☐ Yes ☐ No
Mitral valve prolapse	☐ Yes ☐ No	Arthritis	☐ Yes ☐ No	Drug dependency	☐ Yes ☐ No
Heart valve replacement	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No	**WOMEN:**	
Stents	☐ Yes ☐ No	Trigeminal Neuralgia	☐ Yes ☐ No	Are you pregnant?	☐ Yes ☐ No
Artificial joint	☐ Yes ☐ No	Fibromyalgia	☐ Yes ☐ No	Due date _____	
Asthma	☐ Yes ☐ No	TMJ problems	☐ Yes ☐ No	Are you nursing?	☐ Yes ☐ No
Seasonal allergies	☐ Yes ☐ No	Thyroid problems	☐ Yes ☐ No		

Allergies

☐ Latex ☐ Penicillin or Amoxicillin ☐ Local anesthetics (Novocain) ☐ Codeine or other narcotics

☐ Aspirin ☐ Advil (Ibuprofen) ☐ Other _____

MEDICATIONS *or list attached*

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Other Concerns: _____

_____

To the best of my knowledge, all the above answers are true and correct. I will inform Dr. Osmond of changes in my health and/or medication.

_____ _____

Signature of Patient, Parent or Guardian *Date*

Endodontic (Root Canal)
Informed Consent

- The purpose of root canal therapy is to retain teeth that would otherwise have to be extracted. However, it is a biological procedure and results cannot be guaranteed.
- Occasionally, and despite our best efforts, a tooth that has undergone root canal therapy may require re-treatment, root canal surgery or extraction.
- We make special efforts to preserve the crown/bridge of teeth we treat, but despite our best efforts occasionally a crown/bridge may fracture or come off and require a new restoration.
- It is important for Dr. Osmond to have accurate and complete medical information to prevent unnecessary complications during your treatment.
- Treatment may require multiple visits. It is important that you maintain scheduled appointments or the infection may reoccur.
- If any unforeseen condition arises in the course of treatment, you authorize Dr. Osmond, in his judgment, to perform different or additional procedures from those now contemplated.
- The most common potential risks include, but are not limited to:
  Swelling; sensitivity; bleeding; pain; infection; numbness and/or tingling sensation in the lip, tongue, chin, gums, cheeks, and teeth, which is transient but on infrequent occasions may be permanent; reactions to injections; changes in occlusion (biting); jaw muscle cramps and spasm; tempromandibular joint (TMJ) difficulty; loosening of teeth, crowns or bridges; referred pain to ear, neck and head; delayed healing; sinus perforations; treatment failure; complications resulting from the use of dental instruments (broken instruments - perforation of tooth, root or sinus), medications, anesthetics and injections; discoloration of the face; reactions to medications causing drowsiness and lack of coordination; and **antibiotics may inhibit the effectiveness of birth control pills.**
- In most cases, there is only mild discomfort following each treatment. This is usually controlled with ibuprofen, Tylenol, aspirin or prescribed medication.
- Final restoration of the tooth that has undergone root canal therapy is essential for retention of the tooth. **A final restoration (crown) should be completed within 30 days of root canal therapy.**

I authorize Dr. Osmond and staff to treat tooth #_____ , due to endodontic disease, by:

- ○ Root canal treatment
- ○ Root canal retreatment
- ○ Periapical surgery
- ○ Other _____

By signing below, I have read and understand this form and have had all my questions answered.

_____ _____

Patient/Guardian Signature ***Date***



Steve Osmond, DDS, MSD
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Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I have received a copy of this office's notice of privacy practices.
(YOUR COPY IS THE NEXT PAGE)

_____
Print name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

_____

_____

Steve Osmond, DDS, MSD
Practice Limited to Endodontics

THIS IS YOUR COPY (if you would like it)
Notice of Privacy Practices

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.

Our Legal Duty
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect (August 1, 2008), and will remain in effect until we replace it.

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

You may request a copy of your 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.

Uses and disclosures of health information
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

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

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To your family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

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

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

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (Such as voicemail messages, postcards, or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information) You May obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $0.50 for each page, $30.00 per hour for staff time to locate and copy our health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other that treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before August 1, 2008. 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 these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (Except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form.

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 you disagree with a decision we made about access to your health information or in response to a request you made to amend you restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative 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 Officer: Steve Osmond
Telephone: (541) 776-7640
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