SOUTHWEST ENDODONTICS

Gustavo E. Fuentes, D.M.D.

Practice Limited to Endodontics

West Metro Centre • Suite 106
13650 Metropolis Avenue • Fort Myers, FL 33912
(239) 561-3636 Fax (239) 561-3699

FINANCIAL POLICY

We require that all fees be paid in full. To do otherwise would shift the cost of unpaid services to other patients.

PATIENTS WITHOUT DENTAL INSURANCE. Payment is due at the time of service. We accept cash, check, Care Credit® or credit card.

PATIENTS WITH DENTAL INSURANCE. Keep in mind that your insurance plan is a contract between you, your employer and the insurance company. ***For your convenience we will accept direct payment from your insurance company, when you pay the estimated co-payment at the time of treatment.*** (Prompt reimbursement will be made for any overpayment.)

If your insurance company has not paid your account in full 60 days after the claim has been filed, immediate full payment of your account is due.

CONSULTATIONS. Full fee is due at appointment regardless of insurance coverage.

PATIENTS WHO ARE MINORS. Minors must be accompanied by the parent or guardian responsible for payment.

NOTE: If special or unusual financial considerations are necessary, discuss them with the officer manager. Thank you for your understanding.

I have read, understand and agree to the above financial policy.

Signature _____ Date _____

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PATIENT INFORMATION

DATE _____

ABOUT YOU:

Name (Mr. Mrs. Ms.) _____ Birthday _____

Address _____ S.S.# _____

City _____ Home Phone _____

State _____ Zip Code _____ Work Phone _____

Driver's License# _____ State _____ Marital Status _____

Employer _____ Occupation _____

Employer's Address _____ City _____ State _____

Your Dentist _____ Your Physician _____

ABOUT YOUR SPOUSE:

Name _____ S.S.# _____ Birthday _____

Employer _____ Phone _____ Occupation _____

ABOUT PERSON RESPONSIBLE FOR THIS ACCOUNT:

Name _____ Relationship _____ Home Phone _____

Address _____ City _____ State _____ Zip Code _____

Employer _____ Work Phone _____ S.S.# _____

Confidential

(over)

MEDICAL HISTORY

Are you currently under the care of a physician? ❑ YES ❑ NO

If yes, for what condition? _____

Please list each prescription / over the counter medication you take _____

_____

_____

Do you have any health condition the doctor should know about? ❑ YES ❑ NO

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

YES	NO		YES	NO	
❑	❑	Cancer?	❑	❑	Sinus trouble?
❑	❑	Rheumatic Fever/Rheumatic Heart?	❑	❑	HIV+/AIDS?
❑	❑	Heart Trouble/Heart Attack?	❑	❑	Tuberculosis?
❑	❑	High Blood Pressure/Stroke?	❑	❑	Difficulty Breathing/Emphysema?
❑	❑	Prosthetic Heart Valve?	❑	❑	Asthma/Hay Fever?
❑	❑	Mitral Valve Prolapse?	❑	❑	Seizures/Fainting Spells?
❑	❑	Heart Surgery/Pacemaker?	❑	❑	Radiation Treatment?
❑	❑	Artificial Joint?	❑	❑	Kidney Disease?
❑	❑	Excessive/Abnormal Bleeding?	❑	❑	Diabetes?
❑	❑	Hepatitis/Jaundice/Liver Disease?	❑	❑	Ulcers/Colitis?

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING:

❑YES	**❑NO**	Penicillin	**❑YES**	**❑NO**	Sulfa	**❑YES**	**❑NO**	Latex Allergy
❑YES	**❑NO**	Erythromycin	**❑YES**	**❑NO**	Codeine	**❑YES**	**❑NO**	Dental Anesthetics
❑YES	**❑NO**	Tetracycline	**❑YES**	**❑NO**	Aspirin	Other _____		

FOR WOMEN: Are you taking birth control pills? _____ Are you pregnant? _____

Due Date? _____ Are you nursing a baby? _____

SIGNATURE OF PATIENT _____ **(OR PARENT IF PATIENT IS A MINOR)**

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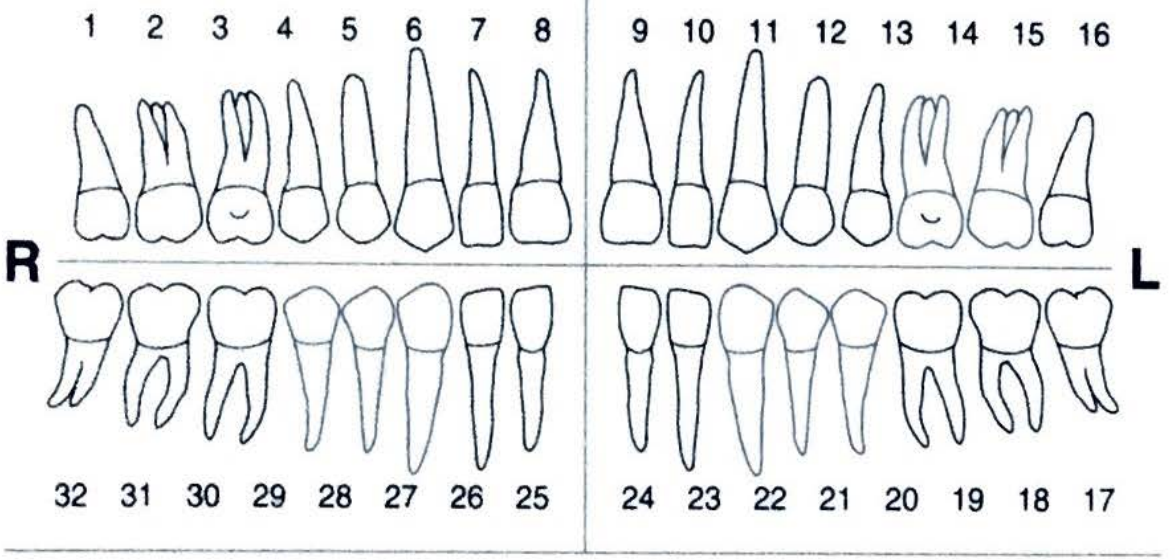
Date: ____/____/_____ Appointment Date: ____/____/_____ Time: ____ : ____ ❑ AM ❑ PM

introducing: _____

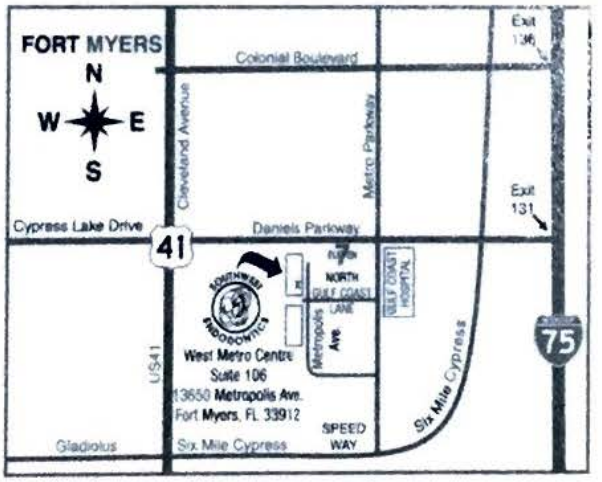
Referring Doctor: _____

Please circle specific area of concern



- ❑ Consultation Only
- ❑ Consultation and treatment if indicated
- ❑ Re-treatment
- ❑ Please create post space
- ❑ Surgery

Remarks: _____



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ENDODONTIC CONSENT AND INFORMATION FORM

Endodontic (root canal) therapy is performed in order to save a tooth which otherwise might need to be removed. This is accomplished by conservative root canal therapy, or when needed, endodontic surgery.

1. Treatment may require multiple visits.

2. In most cases, there is only mild discomfort following each treatment. This is usually controlled with aspirin, Tylenol, ibuprofen, or prescribed medication.

3. Endodontic treatment has a high degree of success. As any medical or dental treatment, however, this treatment has no guarantee of success for any length of time. Teeth with previous root canal treatment will have a lower success rate.

4. The most common complications with root canal therapy include, but are not limited to:
   a. Continued infection requiring endodontic (root canal) surgery or extraction of the tooth.
   b. Calcified canals or canals blocked by broken instruments requiring endodontic (root canal) surgery or extraction of the tooth.
   c. Pain, requiring use of medication.
   d. Side effects and reactions to medication.
   e. Fractures (breaking) of the root or crown of the tooth during or after treatment. It is recommended that all posterior teeth be crowned following root canal treatment. If your tooth already has a crown, there is a chance it will need to be replaced due to decay or loss of structural support. Porcelain crowns are subject to breakage.
   f. 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.
   g. The use of local anesthesia may cause paresthesia (numbness or tingling) in the area of the face, lip or tongue although quite rare, and usually temporary may be permanent.
5. Other treatment choices include no treatment, waiting for more definite development of symptoms, and tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infection to other areas.

6. If you have any questions, please ask.

"I have read and understand the above, and hereby consent to treatment"

_____ _____

Signature of Patient, Parent, or Guardian Date

_____ _____

Witness Date

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