Paul B. Langer, D.D.S LLC

N.J. Specialty Permit #3857
Practice Limited to Endodontics
908-654-3636

Date:

Patient Information

Name _____ Soc. Sec. #_____
Last Name First Name Initial

Address _____ Home Ph. _____

City _____ State _____ Zip _____

Sex ❒ M ❒ F Age _____ Birthdate _____ ❒ Single ❒ Married ❒ Widowed ❒ Separated ❒ Divorced ❒ Domestic Partner

Patient Employed by _____ Occupation _____

Email _____ Bus. Ph. _____ Cell. Ph. _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. #_____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Bus. Address _____ Bus. Ph. _____ Cell. Ph. _____

Insurance Company _____ Subscriber ID# _____ Group # _____

Secondary Insurance

Is patient covered by additional insurance? ❒ Yes ❒ No

Name of Insured _____ Relation to Patient _____ Birthdate _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Employer _____ Bus. Ph. _____

Insurance Company _____ SS# or Subscriber ID# _____ Group # _____

Method of Payment

Which of the following methods of payment will you be using? (Fees must be paid in full at the completion of treatment.)

Method of Payment: ❒ Cash ❒ Check ❒ VISA ❒ MC ❒ Discover ❒ Care Credit

All information written is true and complete. **SIGNATURE:** _____ **DATE:** _____

If dental insurance applies: Although this office files insurance claims as a service to the patient, the insurance contract is between the patient and the insurance company. As we have no control over the insurance company's method of payment or amount of payment, any difference of payment is entirely the responsibility of the patient. **INITIALS:** _____

HIPAA Acknowledgement of Receipt of Notice of Privacy Practices

PLEASE PRINT NAME: _____ SIGNATURE: _____ DATE: _____

****You may refuse to sign this acknowledgement** ❒ Patient refused to sign HIPAA _____

Updates (date & initial) _____ _____ **HIPPA APPROVED** _____ _____

MEDICAL HISTORY

Please complete the following questions so that we may thoroughly diagnose your condition. The information you provide is for our records and will be considered strictly confidential. In addition, it is your responsibility to update this medical history when any changes occur.

	Yes	No
1. Has there been any change in your general health within the past year?	❑	❑
Please specify _____		
2. Are you under the care of a physician for a current problem?	❑	❑
Reason _____		
3. Have you been hospitalized within the past five years?	❑	❑
Reason _____		
4. Are you currently taking any medications or drugs?	❑	❑
Please list _____		
5. Have you received therapy for alcoholism or drug addiction during the past five years?	❑	❑
6. Have you ever had any ALLERGIC OR ADVERSE REACTIONS to **LATEX**, anesthetics, antibiotics, or other medications?	❑	❑
Please specify _____		
7. Have you ever had abnormal bleeding with previous extractions, surgery, or trauma?	❑	❑
8. Have you ever required a blood transfusion?	❑	❑
Please explain _____		
9. Have you ever had surgery and/or radiation for a tumor, growth or other condition?	❑	❑
10. Date of last physical exam _____		

11. Do you have or have you had any of the following (please check):

- ❑ High blood pressure
- ❑ Heart murmur of prolapsed valve (MVP)
- ❑ Joint prosthesis (hip, knee, etc.)
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Congenital heart disease
- ❑ Do you have a pacemaker or a Cochlear implant?
- ❑ Cardiovascular disease: heart attack, stroke, by-pass
- ❑ Are you taking any blood thinners?
- ❑ Prosthetic heart valve
- ❑ Blood disorder (e.g., anemia)
- ❑ STD
- ❑ HIV / AIDS
- ❑ Asthma
- ❑ Temporomandibular joint problems (TMJ)
- ❑ Tobacco use
- ❑ Sinus trouble
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Stomach ulcers, colitis
- ❑ Hepatitis, jaundice, liver disease
- ❑ Kidney problems
- ❑ Psychiatric treatment
- ❑ Fainting spells or seizures
- ❑ Epilepsy
- ❑ Cancer
- ❑ Are you currently, or have you taken medicines for Osteoporosis?
- ❑ Delay in healing

12. Do you have any disease, condition, or problem not listed above?	❑	❑
Please specify _____		
13. Are you required to take premeds prior to dental treatment?	❑	❑

Women:

14. Are you pregnant?	❑	❑
15. Are you nursing?	❑	❑
16. Do you take birth control pills?	❑	❑

If YES, be advised that if you take antibiotics, an alternate method of birth control must be used.

All of the above information is true to the best of my knowledge.

PERMISSION FOR ROOT CANAL TREATMENT - I, the undersigned, consent to the performing of any dental procedure of the tooth which may be decided upon to be necessary or advisable in the opinion of the doctor. I also understand my other option is extraction. I also understand that only the root canal treatment is to be done at the office. The permanent (outside) restoration (filling, inlay, crown, etc.) will be completed by my regular dentist.

Date _____ Signature of Patient* _____

*All signatures must be by parent or guardian if patient is under the age of 18.

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TERMS OF RENDERING SERVICES AND GUARANTEE

I, the undersigned, for and in consideration of Dr. Paul B. Langer providing endodontic services (Including consultation, radiographic imaging and treatment) hereby agree as follows:

A. Estimated payments shall be made on the date of treatment.
B. Any bill not paid in full within 30 days of final treatment shall include a finance charge of 1 ½ percent per month on the unpaid balance.
C. In the event that my account is referred to collection, I agree to pay all the finance charges, collection cost, and attorney's fees equal to 33% of the unpaid balance.
D. I expressly waive Notice of Indebtedness, default, presentment, demand, protest and notice of protest on any and all forms of such indebtedness; and. I expressly consent to the Jurisdiction of New Jersey, Venue of Union County, and the laws of the State of New Jersey control.
E. I understand the payment being made on the date of treatment is only an estimated amount based on insurance information obtained on the date of treatment. Any balance carried over after insurance is processed is my sole responsibility.
F. I personally guarantee all payments.

Date_____

_____
Signature of Patient or (Guarantor)

Signature on File

Authorization
I authorize the release of all information, records and x-rays to my insurance company. A copy of this statement and signature or the statement "Signature on File" is authorized in-lieu of my original signature.

Patient's Signature

Assignment of Benefits
I hereby assign all insurance benefits to the above named dentist otherwise payable to me. A copy of this statement and signature or the statement "Signature on File" is authorized in-lieu .of my original signature on my insurance form.

Patient's Signature

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HIPAA

The Department of Health and Human Services has established a "Privacy Rule" to help insure the personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal dental information and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal dental health information, but this must be in writing. Under this law, we may have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name_____ **Signature**_____

Date_____

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Root Canal Therapy

1) Root Canal Therapy is a relatively Painless Procedure and averages one to two visits. Time spent at each appointment is also variable and may range from very short to very long. This is determined by the complexity of the particular case.

2) During the course of treatment there is generally no discomfort. Occasionally between appointments reactions may occur, including but not limited to a dull ache or throb, soreness or tenderness, and sometimes severe discomfort and swelling. These complications are generally short-lived and are gone within a few days. These reactions may sometimes prolong treatment, but the chance of success does not have to lessen. If a severe reaction occurs, please call this office. For minor discomfort, over-the-counter medication, such as ibuprofen, is usually adequate.

3) No tooth will be treated unless there is a good chance for success. While there can be no certainty of success, healing is expected in 90%+ of the cases. If the prognosis is less, you will be informed. Sometimes Root Canal Therapy will not work. Additional procedures may then become necessary, including retreatment or surgery.

4) Between visits and after completion, brush teeth gently and do not chew anything on the tooth to avoid fracturing it or losing the temporary filling.

5) Following Root Canal Therapy, you will be referred back to your dentist for proper, final restoration of the tooth, usually a crown or filling.

6) Take all medications as prescribed.

7) Root Canal Treatment is never easy: it may be difficult or very technical. This is due to factors, such as the anatomy of the tooth, e.g. long, twisted, narrow or tortuous canals. Problems may arise during the course of treatment including the separation of instruments or perforations of the canal. The occurrence of these or other problems does not necessarily imply that the procedure will not have success.

8) You are responsible to make and keep all appointments to complete treatment in a timely manner. Failure to complete treatment or prolonging treatment may result in fracture, reinfection or loss of the tooth.

9) I, the under signed, have been given the opportunity to ask any questions, and consent to the dental procedures decided upon to be necessary or advisable in the opinion of Paul B. Langer, D.D.S.(this includes the initial examination / Consultation, radiographic images and treatment).

Signature_____ Date_____