# Cascade Endodontics / Dr. Jon Jenson D.D.S. 1375 E. 800 N. Orem, UT 84097

**Patient Information:**

First: ________________________ MI: ______Last:_________________________ D.O.B.________________

**If under the age of 18:** ⟶ Responsible Party's Name:___________________________________

Relationship to Patient: _____________________________________

Street:____________________________________ Home #: ______-_______-___________

City:_______________ State: _____ Zip: ______ Cell #: ______-_______-___________

Email: __________________________

Employer: ________________________________ Work #: ______-_______-___________

Sex: F M Marital Status: S M D W SSN: __________________________

General Dentist: __________________________ Referred By (if different from GD): ________________________

First Last

**Primary Dental Insurance Information:**

Company:___________________________________

Address:____________________________________

____________________________________

Phone #: __________________________________

Name of Insured:_____________________________

Address:____________________________________

____________________________________

Phone #: __________________________________

D.O.B. ___________ SSN/ID#_________________

**Secondary Dental Insurance Information:**

Company:___________________________________

Address:____________________________________

____________________________________

Phone #: __________________________________

Name of Insured:_____________________________

Address:____________________________________

____________________________________

Phone #: __________________________________

D.O.B. ___________ SSN/ID# _________________

**Financial Responsibility:** The undersigned jointly and severally agree to pay for services rendered and all products provided as part of the treatments and services provided by this office. It is understood and agreed that charges not paid may be placed with an attorney or collection agency. It is understood and agreed that reasonable attorney fees and/or open account interest charges assessed are payable by the undersigned. To the extent not expressly prohibited by applicable law, the undersigned, jointly and severally agree to pay all charges not paid in full to this office by an insurance company or other third-party payer.

**Assignment of Benefits/Patients with Dental Insurance**: Dr. Jenson's practice is a specialized practice. We are preferred providers for some insurance companies. The undersigned patient hereby authorizes that payment of insurance or other benefits be made on the patient's behalf to this office. The undersigned agrees to assist in the processing of claims for benefits. The patients' estimated portion of the bill will be required at the time of service.

We are not a preferred provider for all insurance companies. In certain cases your insurance check may be made payable to you and sent directly to you. When an insurance check is sent to you, the entire amount of the payment of services we have provided is due to us immediately.

**Patients with no dental insurance:** Payment in full is required at time of services unless other acceptable written arrangements have been made with the office manager prior to time of treatment. This office will accept all major credit cards. Our office will also accept payment through Care Credit. They are an independent dental credit card company unaffiliated with our office. We do have Care Credit applications available in our office. Patients who are not accepted by Care Credit must make other arrangements for payment prior to treatment.

Financial arrangements must be made prior to starting any dental treatment. Failure to honor agreement will result in account being sent to a collection agency with no further arrangements available.

**A consultation fee will be assessed and may be required at time of service.**

Dr. Jenson may require that 3-D Cone Beam (CT scan) be taken to properly diagnose treatment. As a courtesy to our patients, only a portion of the fee is due at the time of service. The CT scan is used strictly for our purposes; however, if a copy of the CT scan is requested, the full cost of the scan must be paid to our office before we can provide a copy of the requested scan.

**I have read and understand the above patient responsibilities. I understand and hereby agree to the above as conditions and consideration for the services rendered to me. I also understand that if my account goes without payment that it may be turned over to a collection agency and listed with the credit bureau. I agree to pay all attorneys fees, court costs, filling fees, interest and all collection cost which may be assessed by any collection agency retained to pursue the matter.**

I hereby authorize and request that Dr. Jenson and Cascade Endodontics release to my dentist and/or insurance companies the complete dental records in your possession concerning the treatment in this office.

_______________________________________________ ________________

Signature of Patient or Legal Guardian Date

**MEDICAL HISTORY**

Patient Name_____________________________________________ Today's Date________________

1. Are you taking any medications at this time? Y N
   If yes, please list them here: ______________________________________________
   ___________________________________________________________________________
2. Are you currently under a physician's care? Y N
   Explain ______________________________________________________________

3. Please circle any condition(s) that you have had:

| | | |
|---|---|---|
| Allergy to latex | Diabetes | HIV/AIDS |
| Anemia | Epilepsy/Seizures | Kidney/Liver Problems |
| Artificial Heart Valves | Glaucoma | On Aspirin/Blood Thinner |
| Artificial Joints | Heart Trouble | Rheumatic Fever |
| Asthma | Hepatitis | Tuberculosis |
| Bleeding | High Blood Pressure | |

4. Have you ever taken Fosamax, Actonel, Boniva, or any other drugs prescribed to decrease the resorption of bone as in osteoporosis or any drugs for metastatic bone cancer? Y N
5. Have you ever been told you need to pre-medicate before dental treatment due to a heart condition or joint replacement? Y N
6. Is there any other information that should be known about your health or about previous dental visits?
   ___________________________________________________________________________
7. Have you ever had any other unusual or allergic reaction to an anesthetic or drug? Y N
   If yes, please list them here:_______________________________________________

8. **Emergency contact**:____________________ **Relationship to patient**:______________________
   **Cell #: _____-______-__________** **Home #: _____-______-_________**

**ENDODONTIC CONSENT AND INFORMATION FORM**

Endodontic (root canal) therapy is performed to save a tooth which might otherwise need to be extracted. The alternatives to endodontic therapy include no treatment, waiting for more definitive development of the symptoms, or tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and spread of infection to other areas.

Endodontic or root canal therapy is cleaning, shaping, disinfecting and filling the space inside the root of the tooth. A treated tooth usually functions normally and is a pulpless tooth, not a dead tooth. Treatment will require one or more visits depending upon the condition of the tooth. Almost always a local anesthetic will be needed to anesthetize (numb) your tooth. A minimal number of x-rays will be taken as indicated by the needs of treatment. Please be advised of the following:

1. The root canal fee will vary depending on the tooth being treated and the complexity of the case. Other procedures may incur additional charges.
2. Upon completion of root canal therapy in this office I shall return to my referring and/or regular dentist for a permanent restoration of the tooth involved. This restoration may be a crown (cap), onlay, silver filling or other presented by your general dentist. Otherwise the tooth may break or split, requiring extraction.
3. Routine Endodontic cases are successful about 90% of the time. Endodontics, as with any branch of medicine or dentistry, is not an exact science. Thus no guarantee of treatment can be given or implied. If the original treatment is not successful, it may be retreated, a surgical procedure may be required or the tooth may need to be removed. Endodontic treatment started in other offices or re-treatment cases may have a different outcome than expected under optimal conditions.
4. **Possible unavoidable complications of endodontic therapy include but are not limited to:** swelling, soreness, discoloration, jaw muscle spasm, fracture of the crown or root of tooth, separation of root canal instruments during treatment, blocked canals due to a filling, prior root canal treatment or natural calcifications, damage to existing crowns/bridges, adverse reactions to anesthetics and medications administered and prescribed for treatment. During treatment complications may be discovered which make treatment impossible or which may require dental surgery.

I fully understand the above statement in the consent form. I hereby give my consent to the performance of dental treatment. I further give my consent for the administration of medications, anesthetics and procedures performed understanding the risks involved.

_____________________________________________ ____________________

Signature of Patient or Legal Guardian Date

**Cascade Endodontics**
**1375 East 800 North, Suite 203**
**Orem, UT 84097**

**Patient Consent for Use and Disclosure of Protected Health Information**

With my consent, **Cascade Endodontics**, may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Please refer to **Cascade Endodontics Notice of Privacy Practices** for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Cascade Endodontics** reserves the right to revise its Notice of Privacy Practice at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to **Cascade Endodontics 1375 East 800 North Suite 203 Orem, UT 84097**.

With my consent, **Cascade Endodontics**, may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care, Including laboratory results among others.

With my consent, **Cascade Endodontics**, may mail to my home or other designated locations any items that assist the practice in carrying out treatment, payment and healthcare operations, such as patient statements. I have the right to request that **Cascade Endodontics** restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to **Cascade Endodontics** use and disclosure of my protected health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

If I do not sign this consent, Cascade Endodontics, may decline to provide treatment to me.

| | |
|---|---|
| ______________________________________________ | ________________ |
| Signature of Patient or Legal Guardian | Date |
| ______________________________________________ | ________________ |
| Printed Name of Patient or Legal Guardian | Date |