



Cornerstone Endodontics, LLC

Dr. Jamie Ring | Dr. Karla Ring

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Welcome

Our main goal is to help you achieve and maintain your maximum oral health. Please fill out this form as completely as possible. We want to make sure we are well informed about your medical history, current medications, and any other factor that might affect your dental health treatment. The better we communicate, the better able we are to take great care of you.

Patient Registration:			
First Name:	M/I:	Last Name:	DOB:
Sex: M F	Cell Phone:		Home Phone:
Email:	SSN:		
Address:			
City:	State:	Zip:	
Guardian/Guarantor:		Relationship:	
		Phone:	
Employer:		Phone:	
Referring DDS Name:		General DDS:	
Pharmacy:		Phone:	
Physician:		Phone:	

Dental Insurance/Financial Policy		
Insurance Company:	ID:	Group:
Policy Holder:	DOB:	SSN:
Phone:	Employer:	
Secondary Insurance	ID:	Group:
Policy Holder:	DOB:	SSN:
Phone:	Employer:	

Acknowledgements | Signatures

I acknowledge that the information I give in this form is correct to the best of my knowledge, and I understand that this information will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in any insurance or medical status.

I agree to be financially responsible for services rendered which are not covered by my dental insurance plan (if applicable). To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my insurance claim. I authorize and direct payment of the dental benefits, otherwise payable to me, to Cornerstone Endodontics, LLC. In the event my account is past due and sent to collections, I agree to pay for all fees associated with the account collection, court costs and attorney fees. * See additional financial policies on page 2.

Print Name: _____ Date: _____
Signature: _____

Office Financial Policy

We are committed to helping you maximize your dental benefits and are happy to assist in filing any insurance claims. Dental insurance is a contract between the insurance company and the policy holder. It is not a guarantee of benefits. As a courtesy we will file your claim, however, full payment for treatment is due at time of service. Any benefits covered by your insurance provider will then be directed to the policy holder.

We are network providers for Ameritas, Principal Life, The Standard, Blue Cross & Blue Shield, and Delta Dental. We will *estimate* the portion your insurance is going to pay and collect anything *estimated* beyond the covered benefits at the time services are rendered

Please note:

>If your insurance pays more than the estimated amount, a refund check from this office will be mailed within 30 days from the date payment is received by this office. Payments are typically batched at the end of the month.

>If your insurance pays less than the estimated amount, you will receive a statement from this office for the remaining balance due.

Due to COVID 19: In the event of a retroactive termination of insurance benefits, you agree to be responsible for and agree to pay all accumulated charges associated with your account balance.

Returned checks:

Your account will be assessed a fee (current bank fee) for any checks returned by the bank.

Payments:

Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued.

Accounts are past due if not paid within 30 days.

Past due accounts:

If your account becomes past due, we will take necessary steps to collect the debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If the account balance is turned over for legal judgment, you agree to pay all court costs and fees incurred. You understand that if the past due account is submitted to a collection agency or attorney and taken to court, information regarding your treatment at our office may become a matter of public record.

Cancellation Policy:

We strive to render excellent dental care to you and the rest of our patients. When an appointment is scheduled, that time has been set aside for you. We ask that you give our office 48 business hours' notice in the event you need to reschedule your appointment. A non-refundable deposit of \$200 may be charged to you and applied towards future treatment in order to reschedule. This fee cannot be billed to your insurance company and will be your direct responsibility.

Records Release:

In the event you request your records to be transferred to another practitioner, there is a records fee of \$10.00 for materials and postage. If there is a balance remaining on your account, no records will be transferred until the balance is paid in full.

HIPAA

I understand that under the Health Information Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for:

>Conduct, plan and direct my dental treatment and follow-up care among the health care providers who are involved in that treatment directly and indirectly.

>Obtain payment from third-party payors.

>Conduct normal health care operations, including quality assessments and physician certification.

I acknowledge having received, read, and understood the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand the Cornerstone Endodontics have the right to change the Notice of Privacy Practices from time to time, and that I may contact Cornerstone Endodontics at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that Cornerstone Endodontics is not required to agree to my requested restrictions, but that formally agreed upon restrictions are legally binding.

Name of person(s) for authorized release of information: _____

Relationship to Patient: _____

Print Name: _____ **Date:** _____

Signature: _____

Medical History Form						BP:	
First Name:			Last Name:			DOB:	
Are you under the care of a physician other than routine physicals?						YES	NO
			If so, explain:				
Do you take a pre-medication prior to dental treatment? (heart joints)						YES	NO
			If so, what:				
Do you have a prosthetic joint?						YES	NO
			If so, where:		How long:		
Do you have a heart valve replacement or vascular graft?						YES	NO
If so, describe which:							
Did/Do you currently have...	YES	NO	Notes	Did/Do you currently have...	YES	NO	Notes
Damaged Heart valves/Heart Murmur/Mitral Valve Prolapse				Allergy/Hay Fever/Sinus problems			
Rheumatic Fever/Rheumatic Heart Disease				Pain/clicking of jaws when eating/TMJ			
Pacemaker				HIV/AIDS			
Heart Attack(s)/surgeries				Blood disorder Anemia			
Angina				Stomach ulcers/intestinal problems			
Stroke							
High Blood Pressure				Eye disease/glaucoma			
Hepatitis/Liver Disease				Cancer/Chemotherapy			
Kidney Trouble/Dialysis				Seizures/Epilepsy			
Diabetes				Arthritis/Joint disease			
Thyroid trouble				Mental health/psychological disorder			
Asthma							
Tuberculosis				History of smoking			
Emphysema/COPD				Other			
Women, are you pregnant							
MEDICATIONS:				ALLERGIES	YES	NO	List Others
Please list all medications (include OTC; ie: Aspirin)				Local anesthetics			
				Penicillin			
				Codeine/narcotics			
				Aspirin/NSAIDs			
				Latex			
				Sign/Date :			

CONSENT FOR ENDODONTIC THERAPY

Patient Name: _____ Tooth/Teeth #: _____

1. **Consent:** I hereby give my consent to perform endodontic therapy on the tooth or teeth listed. I understand that root canal therapy (RCT) is a procedure to retain a tooth which may otherwise require extraction.
2. **Initial Success Rate:** I understand that root canal therapy has a very high degree of clinical success (90-95% of the routine cases are successful). I also understand that RCT started in another office *may* have a lower success rate. I also understand that with any branch of medicine or dentistry, guarantee of successful treatment cannot be given or implied even when treatment is performed under optimal conditions using state of the art optics, materials and instrumentation.
3. **Retreatment Success Rate:** I understand that an endodontic Retreatment is more complex and involves both a time and a monetary investment due to the possibility of multiple visits and procedure specific dental supplies needed to provide the appropriate care. Retreatment cases may also have a lower success rate even when the procedure is carried out under optimal conditions using state of the art optics, materials and instrumentation. As in routine RCT, a guarantee of successful treatment cannot be given or implied.
4. **Initial Additional Treatment:** I understand that if the affected tooth and surrounding tissues do not favorably respond to endodontic treatment; a retreatment, a surgical procedure (apicoectomy) or possible extraction may be required at an additional expense.
5. **Crown & Restoration:** I understand that to accomplish the root canal procedure it is necessary to alter the existing tooth structure and/or restorations. These alterations require the placement of a new restoration/filling and may require a full coverage crown. I understand that proper restoration of the tooth after root canal therapy is a necessity and that a crown is generally recommended on posterior teeth following the procedure to protect the tooth from fracturing. The fee for endodontic treatment does not include these restorative procedures. I understand that it is my responsibility to have an appropriate restoration placed following the root canal procedure in a timely manner as recommended.
6. **Recall visit:** I understand that a recall examination and radiograph of the tooth with my general dentist may be recommended to evaluate the healing response. I understand that it is my responsibility to follow through with the recall visit.
7. **Procedure/Radiographs:** I understand that treatment will be performed in accordance with accepted methods of clinical practice. This will require the administration of local anesthetic agents and the placement of a rubber dam. In rare instances, the administration of local anesthesia may result in transient or permanent numbness of the anesthetized area. Also, a number of radiographs may be necessary to diagnose and accomplish the endodontic procedure. The number of radiographs required will vary with the complexity of the case. Radiographs provided by a general dentist are often helpful as an aid, but original pre-operative and post-operative radiographs are required for proper diagnosis and/or documentation.
8. **Complications:** Possible complications/challenges of treatment include, but are not limited to:
 - a. Curved canals and/or roots
 - b. Calcifications in the root canal or pulp chamber space
 - c. Procedural difficulties such as the separation of instruments in the root canal space and perforation of the crown or root while identifying the canal space and fractures of existing porcelain/ceramic restorations.
 - d. Fracture of the crown or root
 - e. Infection, swelling or bruising of the adjacent tissues
 - f. Stiffness of the jaw or stretching of the mouth and lips
 - g. Discomfort during or following treatment
 - h. Additional unknown or unspecified problems, the explanation for and the responsibility of which cannot be given or assumed.
9. **Consent or Discontinue:** I understand that I am free to withdraw my consent and discontinue treatment at any time however; complications such as bone destruction, infection, swelling, and/or discomfort, etc. may predictably occur if the endodontic therapy is not completed.
10. **Visits needed:** The number of treatment visits required to complete the endodontic therapy varies with the complexity of each case. Routine cases are generally completed in one or two visits.
11. If at any time I have questions regarding the treatment I am receiving, I can expect a prompt and thorough response.

DATE: _____

Signature of the Patient/Responsible Party

Staff Initials/Date: _____

INFORMED CONSENT CONE BEAM CT SCAN

1. WHAT IS CBCT AND WHY DO I NEED IT?

- a. CBCT stands for Cone Beam Computed Tomography
- b. It is a specialized x- ray technique that produces a 3-D view of your tooth to be examined
- c. It has an advantage over your typical dental x- ray in that it allows the endodontist to enhance treatment planning of the tooth so we may provide the appropriate care. It allows us to see possible cracks and/or fractures of the tooth in addition to atypical and unusual anatomy within the roots. This will enable us to see all nerve canals which need to be treated and thus enhances the success rate of the endodontic therapy. It is highly recommended for teeth with multiple roots (i.e. Molars) and those teeth in need of retreatment therapy. It is mandatory for teeth which will require surgical root canal therapy (i.e. apicoectomy).

2. RADIATION

- a. The CBCT scan presents minimal radiation that is not harmful to you. It is the equivalent of 2 conventional dental xrays. For female patients, please inform the staff if you are or could possibly be pregnant.

3. COST

- a. The cost of CBCT is \$75. This is typically not covered by insurance and will be an out- of- pocket expense.

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

I, _____, being 18 years of age or older, certify that I have read the above statement. I understand the procedure to be used and the benefits and risks of such procedure. I have been given the opportunity to have all my questions answered to my satisfaction.

Please check the following:

I give consent and permission to have CBCT taken _____

I decline the CBCT imagery and its benefits _____

Signature

Date

COVID-19 PANDEMIC - PATIENT DISCLOSURES

This patient disclosure form seeks information from you that we must consider before making treatment decisions during the COVID-19 pandemic.

It is important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with COVID-19.

Please check:	Yes	No
Have you recently or currently have a fever (100.0) or above normal temperature?		
Have you experienced shortness of breath or had trouble breathing?		
Do you have a dry cough?		
Have you recently lost or had a reduction in your sense of smell or taste?		
Have you been in contact with someone who has tested positive for COVID-19?		
Have you tested positive for COVID-19?		
Have you been tested for COVID-19 and are awaiting results?		
Have you traveled outside the United States in the past 14 days?		
Have you traveled within the United States by air, bus or train within the past 14 days?		

A weakened or compromised immune system (which may be due to underlying conditions like cancer, diabetes, asthma, and COPD; treatments like radiation, chemotherapy, and immunosuppressive drugs; and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition or treatment/medication that weakens or compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

I fully understand and acknowledge the above information, risks and cautions regarding a weakened or compromised immune system and have disclosed to my provider any conditions in my health history which may result in a weakened or compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

Signature _____ **Date:** _____

Dental Office Signature: _____ **Date:** _____

COVID-19 PANDEMIC EMERGENCY DENTAL TREATMENT
NOTICE AND ACKNOWLEDGEMENT OF RISK FORM

Our goal is to provide a safe environment for our patients and staff, and to advance the safety of our local community. This document provides information we ask you to acknowledge and understand regarding COVID-19.

Since the nature of our work deals directly with oral membranes and fluids, we must respond in an appropriate and timely manner in order to protect our patients and our staff members. We have always adhered to Universal Precautions in sterilization and disinfection and we will continue to take extra steps to advance our sterilization practices in our office.

COVID-19 is a serious and highly contagious disease. The World Health Organization has classified it as a pandemic. You could contract COVID-19 from a variety of sources. Our practice wants to ensure you are aware of the additional risks of contracting COVID-19 associated with dental care.

COVID-19 has a long incubation period. You or your healthcare providers may have the virus and not show symptoms and yet still be highly contagious. Determining who is infected by COVID-19 is challenging and complicated due to limited availability for virus testing.

Due to the frequency and timing of visits by other dental patients, the characteristics of the virus, and the characteristics of dental procedures, there is an elevated risk of you contracting the virus simply by being in a dental office.

Dental procedures create water spray which is one way the disease is spread. The ultra-fine nature of the water spray can linger in the air for minutes to sometimes hours, allowing for transmission of the COVID-19 virus to those nearby.

You cannot wear a protective mask over your mouth to prevent infection during treatment as your health care providers need access to your mouth to render care. This leaves you vulnerable to COVID-19 transmission while receiving dental treatment.

I confirm that I have read this notice and understand and accept that there is an increased risk of contracting COVID-19 in a dental office or with dental treatment. I understand and accept the additional risk of contracting COVID-19 from contact at this office. I also acknowledge that I could contract COVID-19 from outside this office and unrelated to my visit here. Additionally, should COVID-19 symptoms present 72 hours post-treatment, I confirm that I will inform the office of my state of being.

I have read and understand the information stated above:

Signature _____ **Date:** _____

Dental Office Signature: _____ **Date:** _____