CORNERSTONE ENDODONTICS, PLLC – (402) 421-3636

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Welcome to Cornerstone Endodontics of Lincoln. We are Lincoln's first group endodontic practice. Our doctors and staff are happy to accommodate your needs. In order to better serve you and expedite your treatment faster, please complete the following 6 forms prior to your scheduled appointment. We ask that you bring all forms, completed, to you appointment as well as current dental insurance cards and medication lists. We also ask that you arrive 15 minutes prior to your appointment for proper diagnosis and to maximize your treatment time.

Directions:

If traveling on I-80 from the West, take the Hwy 77 South to Beatrice exit. Exit 397.
Turn left/east on Old Cheney & drive to the stoplight at 34th Street.
At the light, turn right/south & drive for just ½ block.
Turn right into the first parking lot on your right. We are along the west side of businesses in that lot.

If traveling on I-80 from the East from the Omaha area, take the Waverly exit & drive west/left on Highway 6.
At 84th, turn left/south. At "A" street, turn right/west & drive to 70th.
At 70th turn left/south & drive to Old Cheney
At Old Cheney turn right/west & continue driving west to the stoplight at 34th.
At 34th, turn left/south & drive for ½ block.
Turn right into the first parking lot on your right. We are along the west side of businesses in that lot.

If traveling from the South on Hwy 77 from the Beatrice area, take the first Lincoln exit right/east, onto Warlick Blvd. Continue driving east as Warlick curves into Old Cheney & drive to the stoplight at 34th Street.
At 34th, turn right/south & drive for ½ block.
Turn right into the first parking lot on your right. We are along the west side of businesses in that lot.

If traveling from the East from the Nebraska City area, approach Lincoln on Hwy 2 and take the curve left/west onto Old Cheney & continue driving west to the stoplight at 34th & Old Cheney. At that light, turn left & drive south for ½ a block. Turn right into the first parking lot on your right. We are along the west side of businesses in that lot.

From the Norfolk area: Drive South on Hwy 81 for about 61 miles. Turn left/east on NE Hwy 92 for 12 miles.
Turn Right to stay on NE 92 for 2 more miles. Turn slight right onto NE Hwy 15 for about 19 miles.
Turn slight left onto NE Hwy 15 and continue to follow NE 15 south.
Merge onto I-80 East, via the ramp on the left. Drive about 18 miles on I-80 East.
Take the Hwy 77 south to Beatrice exit, Exit 397.
Turn left/east onto Old Cheney & drive to the stoplight at 34th Street.
At the light, turn right/south & drive for just ½ block.
Turn right into the first parking lot on your right. We are along the west side of businesses in that lot.

Demographic Information

Referring/General Dentist: _____ (Name)

Pharmacy: _____ (Name)

Patient Name: _____ (First) _____ (M.I.) _____ (Last)

Date of Birth: _____ **SSN:** _____

Address: _____ (Street) _____ (City) _____ (State/Zip)

Home Phone: _____ **Cell Phone:** _____

Preferred Contact: Home/ Cell/ Email (circle one)

Parent/Guardian (if patient is a minor) _____ **Email:** _____

Emergency Contact _____ (Name) _____ (Phone) _____ (Relationship)

Employment _____ (Employer) _____ (Phone)

For your convenience, we offer several payment options. Please indicate your choice:

1. Payment by: Cash___ Check___ Credit ___ Debit ___ CareCredit®___*(subject to application and credit approval)
2. Flexible Payment Plan administered through CareCredit® Apply prior to appointment at www.carecredit.com

Dental Insurance: _____ Name _____ Group # _____ ID #

Policy Holder Information: Name:_____ DOB:_____ **Spouse/ Guardian of patient (circle one)**

Employer:_____ Phone #_____ SSN: _____

Secondary Dental Insurance: _____ Name _____ Group # _____ ID #

Policy Holder Information: Name:_____ DOB:_____ **Spouse/ Guardian of patient (circle one)**

Employer:_____ Phone #_____ SSN: _____

Appointment 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 and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

_____We require that you give our office 48 hours' notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. A deposit of $200.00 will be charged to you and applied towards future treatment. **The $200.00 deposit is non-refundable if you cancel or no show for this appointment**. This fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee. We must speak with you live to cancel or reschedule an appointment. Messages left after business hours, or not personally answered by Cornerstone Endodontics Staff during our normal business hours Monday through Friday, will not be honored. Office hours are Monday-Friday 8:00 am - 5:00 pm.

Financial Commitment and Records Release:

_____ 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 and not a guarantee of benefits. As a courtesy, we will file your claim, however, payment for treatment is due in full at the time of service. Any benefits covered by your insurance provider will then be directed back to the policy holder. We recommend contacting your provider for a detailed list of covered services.

HIPPA

_____A copy of Cornerstone Endodontics Privacy Practices is available upon request. I agree to be financially responsible for all charges for all services and materials not paid by my dental plan or covered by my 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 the insurance claim. I hereby authorize and direct payment of the dental benefits, otherwise payable to me, directly to Dr. Jamie Ring, Dr. Karla Ring, and Dr. Jeri Rush at Cornerstone Endodontics. In the event my account is past due and sent to collection; I agree to pay for all fees associated with the account collection, court costs and attorney fees.

_____ _____

Signature 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 his 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

HEALTH HISTORY

Patient Name

_____

Patient Birth Date_____

Referring Dentist_____

General Dentist _____

General Information

1. **Medical Doctor**: _____
2. Address: _____
3. Phone # _____
4. **2. Pharmacy**: _____
5. Phone #:

Cardiovascular System

1. High or low blood pressure ……..
2. Heart attack or heart surgery ……
3. Heart murmur (congenital heart disease) ..
4. Chest pain upon exertion (angina) ……..
5. Rheumatic heart disease or fever ……..
6. Stroke ……..

C. Nervous System

1. Epilepsy, convulsions, seizures, faintings
2. Neuritis, neuralgia or numbness ……..

D. Respiratory System

1. Tuberculosis ……
2. Sinus trouble, hay fever, allergies……..
3. Pneumonia, asthma or emphysema ……..
4. History of smoking……..

E. Genitourinary and Gastrointestinal Systems

1. Kidney disease ……
2. Stomach or intestinal problems ……
3. Liver disease, jaundice or hepatitis ……..
4. Ulcers, reflux disease……
5. Eating disorders ……

F. Endocrine Systems

1. Diabetes ……
2. Thyroid disease ……

G. Bones and Joints

1. Osteo - or rheumatoid arthritis ……
2. Joint replacement ……
3. Back, neck or jaw injury ……..

H. Blood-Lymphatics

1. Blood disorder or anemia ……
2. Abnormal bleeding with other procedures

I. Infectious Diseases

1. Hepatitis (A, B, or other) ……
2. AIDS, ARC, HIV, ANTI-HIV ……
3. History of chemical or alcohol dependency

J. Radiation History

1. Have you ever had radiation therapy? …

K. Medication

Are you taking any of the following?

1. Pre-medication prior to dental treatment, due to heart conditions, rheumatic fever, joint replacement.
2. Antibiotics or sulfa drugs……..
3. Anticoagulants (blood thinners) ……..
4. Medicine for high blood pressure……..
5. Cortisone (steroids) ……..
6. Anti-depressants……..
7. Antihistamines……..
8. Aspirin on a regular, ongoing basis …..
9. Insulin or other anti-diabetic medication..
10. Digitalis or other heart medications …
11. Nitroglycerin ……
12. Chemotherapy ……
13. History of diet pills (Fen-phen, etc.)
14. Inhaler, prescription or OTC. ……..
15. Please list all medications**:**

_____

_____

_____

_____

L. Allergies

Are you allergic to or have you had a reaction to:

1. Penicillin, sulfa drugs or other antibiotics .
2. Local anesthetic (Novocain, etc.) ……..
3. Latex ……..
4. Aspirin ……..
5. Metals ……..

M. Do you have a history of:

1. Periodontal (gum) disease ……..
2. Orthodontic treatment ……..
3. Difficulty in opening your jaw ……

N. Women

Are you pregnant?……..
History of breast cancer? ……
Using birth control?

Have your prior dental experiences been:

**Are you in any dental discomfort at this time?
……..

*****Do you have any disease condition or health problem not listed in the previous questions?** ……..

*****Signature of Patient/Responsible Party*****

CONSENT FOR ENDODONTIC THERAPY

Patient Name: _____Tooth/Teeth #: _____

1. **Consent:** I hereby give my consent for Cornerstone Endodontics 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. **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. **Additional Treatment:** I understand that if the affected tooth and surrounding tissues do not favorably respond to endodontic treatment, a surgical procedure (apicoectomy) or possible extraction may be required.

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.
    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

Consent for Use and Disclosure of Health Information

Section A: Patient/Responsible Party Giving Consent

Name: _____ Date: _____
Please Print

Section B: To the Patient – Please read the following statements carefully:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Privacy Practices is available upon request. Our notice is also posted at our office for your review.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

_____ Date: _____
Signature of Patient

If this Consent is signed by a Parent, Guardian or Personal Representative (PR) on behalf of the patient, complete the following:

Responsible Party Signature: _____

Relationship to Patient: _____ Date: _____

Revocation of Consent – Sign only if Patient wants to revoke their Consent

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.
I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

_____ Date: _____
Signature