KENNETH MANGANO, DDS, PA

ENDODONTIC SPECIALISTS

Kenneth Mangano, DDS Michael L. Moreno, DMD Michelle Hack, DDS, MDSc

WELCOME. We appreciate the confidence you have placed in us by choosing us for your endodontic treatment. Our mission is: to provide the highest quality endodontic treatment available, without compromise, in a safe, friendly and comfortable environment. Please complete this form for our records.
Thank you.

PATIENT INFORMATION

Date _____

Name _____ Preferred Name _____

Address _____ Email _____

City_____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

SS# _____ Birth date _____ Sex: M F (circle one)

Is the patient a minor? □ No □ Yes If "Yes" Parent/Guardian Name _____

Patient or Parent/Guardian Employer _____

Person to contact in case of emergency _____ Phone _____

Name of General Dentist _____

Whom should we thank for this referral? (If other than your dentist) _____

DENTAL INSURANCE INFORMATION

Name of Insured (Policyholder) _____ Birth date _____

Employer _____ SS# _____

Insurance Company _____ Phone _____

Group number: _____ Relationship to Patient _____

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FINANCIAL POLICY

The estimated usual fee for your visit today is $_____

The estimated discounted fee according to your insurance plan is $_____

Your estimated portion due today is $ _____

Depending on your specific situation, we occasionally will provide a permanent composite ("white") filling for you. Our fee for this is $232.00. You may have an additional out-of-pocket fee of $0 to $232.00, typically $46.00.

YOUR PORTION OF THE FEE IS DUE AT THE TIME SERVICES ARE RENDERED. In order to avoid any misunderstanding concerning payment of fees and to help us assist you courteously and efficiently, please indicate your method of payment:

_____ Cash
_____ Check (*Post-dated checks are not accepted)*
_____ Credit Card (Visa / MasterCard / Discover / American Express)
_____ Check/Debit Card
_____ CareCredit (interest-free financing for amounts over $300)

As a courtesy, we will file insurance claims for our patients. Please remember that dental insurance coverage is a contract between the patient and the insurance company. **Patients are ultimately responsible for their entire account.**

_____ **In network**: your estimated portion of the fee will be collected at the time of service. If your insurance payment is more or less than anticipated, your account will be adjusted accordingly.

_____ **Out of network**: we will collect the entire fee from the patient at the time of service. You will be reimbursed directly by your insurance company (you still receive your dental benefit). No fee/no interest financing may be available to you.

_____ **Traditional/Indemnity insurance:** We can often accept assignment of your insurance benefits. If this is the case, you will be responsible for your estimated portion at the time of service, and your insurance benefit will be paid directly to the office. If your insurance payment is more or less than anticipated, your account will be adjusted accordingly. If we are unable to verify or estimate your benefits, then the *Out of network* policy above will apply.

Please feel free to discuss any uncertainty regarding fees or insurance coverage with our patient care coordinator. No fee/no interest financing may be available to you.

In the event that an **account becomes overdue**, the patient will be charged and responsible for a **late fee of up to 30% of the balance due (10% per month for each month past due up to 3 months**).

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY. If *In network* or *Traditional/Indemnity* are marked above, I authorize my insurance company to pay (assign) the dental benefits directly to this office. I also verify that I have been given an opportunity to review the *Notice of Privacy Practices* and to retain a copy if desired.

Patient Name (Printed)**:**_____

Signature of Patient (or Parent/Guardian) _____ **Date** _____

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MEDICAL HISTORY

Patient Name:_____ **DOB:**_____ **Date:**_____

(Please circle answer)

Y N Are you in good health?

Y N Are you under the care of a physician? Reason:_____

Physician's Name:_____ Phone # (if known):_____

Y N Have you had surgery or been hospitalized in the last 5 years? Explain:_____

Y N Are you taking any medication - prescribed or non-prescribed - or drug at this time? (**Please include your regular medications and any medications taken for your current dental condition**)

Names of Medications:

_____

_____

_____

Y N Have you ever had an allergic or unusual reaction to any medication? (Penicillin, sulfa drugs, etc.)

Names of Medications:_____

Y N Have you ever had any trouble with prolonged bleeding after dental extractions, surgery, or trauma?

Y N Have you ever required a blood transfusion? Reason & Date: _____

Y N Have you taken cortisone or steroids in the last 2 years? What & how long:_____

Y N Are you required to premedicate with antibiotics prior to dental treatment? Reason:_____

Y N Have you ever had any serious trouble with dental treatment? Explain:_____

Y N Do you usually have problems getting numb for dental treatment?

HAVE YOU EVER HAD: (Please circle answer)

Y N	Rheumatic Fever*	Y N	Diabetes	Y N	Arthritis
Y N	Mitral Valve Prolapse*	Y N	Anemia (incl. Sickle Cell)	Y N	Stomach/Intestinal Ulcers
Y N	Heart Murmur*	Y N	Hemophilia	Y N	Cancer/Tumor/Cysts
Y N	Artificial Heart Valve*	Y N	Blood Disorder/Leukemia	Y N	Chemo/Radiation Trtmt
Y N	Joint Prosthesis (Hip, Knee, etc.)*	Y N	Lung Disease/Emphysema	Y N	Sexually Trans. Disease
Y N	Heart Pacemaker	Y N	Asthma	Y N	Herpes
Y N	Angina or chest pains	Y N	Tuberculosis	Y N	AIDS or HIV Positive
Y N	Heart Attack/Disease/Surgery	Y N	Liver Disease or Jaundice	Y N	Epilepsy or Seizures
Y N	Stroke	Y N	Hepatitis A, B, or C (circle)	Y N	Glaucoma
Y N	High Blood Pressure	Y N	Kidney Disease	Y N	Drug or Alcohol Problem
Y N	Cardiovascular Stent	Y N	Thyroid Disease	Y N	Psychological Disorder
Y N	Hay fever or Sinus Trouble	Y N	Shingles	Y N	Latex Allergy
Y N	Pain in Jaw Joints (TMJ)	Y N	Clench or Grind Teeth		

Y N Do you have any disease, problem, or condition not listed above that you think we should know about?

_____

WOMEN ONLY: (Please circle answer)

Y N Are you pregnant? How many weeks?_____

Y N Are you taking birth control pills?

Y N Are you breast-feeding?

All of the above information is true and correct to the best of my knowledge. If I have any changes in my health or medications I will inform the doctor prior to treatment at the next appointment

Signature of Patient (or Parent/Guardian) _____ **Date** _____

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CONSENT for clinical EVALUATION and, if needed, ROOT CANAL TREATMENT

We would like our patients to be informed about the procedures, number of visits, time required, and fees involved in endodontic (root canal) treatment. Root canal Treatment is performed in order to save a tooth which otherwise might need to be removed. The object of the treatment is to cure or prevent infection of the jawbones and to preserve the healthy function of the tooth. Procedures in this office are performed using local anesthetic. The following discusses possible risks associated with endodontic treatment, as well as other treatment choices.

RISKS: The risks include, but are not limited, to the possibility of instruments separating within the root canals, perforations (extra openings) of the crown or root of the tooth, damage to bridges, crowns, fillings or other restorations, loss of tooth structure in gaining access to canals, and cracked or fractured teeth. During treatment, complications may be discovered which require dental surgery or render treatment impossible. These complications may include, but are not limited to: blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal (gum) disease, and splits or fractures of the teeth. There is always a risk of prolonged or permanent numbness (paresthesia, anesthesia) when using a local anesthetic.

MEDICATION: Prescription medications and over the counter medications may cause drowsiness and lack of awareness and coordination. These effects may be influenced by the use of alcohol and other drugs. It is not advisable to operate any vehicle or hazardous devices while taking these medications.

TREATMENT ALTERNATIVES: Other treatment options include no treatment, waiting for more definite development of symptoms, or tooth extraction. The risks involved in these choices may include pain, infection, swelling, loss of teeth, the spread of infection to other areas, and, in very rare cases, death.

CONSENT: I, the undersigned patient (parent or legal guardian of minor patient), consent to the procedures determined to be necessary or advisable in the professional opinion of the doctor. I also consent to the use of a local anesthetic during procedures performed in this office. I understand that when the root canal treatment is completed a definitive restoration (crown or filling) is required within 6 weeks. Our fee does not include this service. Your referring dentist will render this service, which is equally important for the preservation of your tooth. Delaying the restoration of the treated tooth may result in re-infection, need for endodontic re-treatment, or even loss of the treated tooth.

I understand that endodontic treatment is an attempt to save a tooth that may otherwise require extraction. Although root canal therapy has a high degree of success, it is a biological procedure, so it cannot be guaranteed. Occasionally, a tooth that has had root canal therapy may require re-treatment, surgery, or even extraction.

Patient Name (Printed)**:** _____

Signature of Patient (or Parent/Guardian) _____ **Date** _____

Doctor's attestation of discussion and informed consent for
ENDODONTIC EVALUATION AND NON-SURGICAL ROOT CANAL TREATMENT

Doctor's Name: _____

Signature of Doctor _____ **Date** _____