Our responsibility is to provide you with the highest quality dental care available.

Dr. Gavin L. Criser
ENDODOTICS LTD.
220 Cherokee Road Suite B * Florence, SC 29501
843.662.3336

Consent for Use and Disclosure of Health Information and Acknowledgement of Receipt of Notice of Privacy Practices.

Name of patient giving consent: _____

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 to our treatment, payment activities and healthcare operations, of the uses and disclosures we may make to your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read carefully and complete before signing this consent.

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.

You may obtain a copy of our Notice of Privacy Practices, including revisions of our notice, at any time by contacting:
Dr. Gavin Criser or Office Manager
220 Cherokee Road Suite B
Florence, SC 29501
843-662-3336
843-667-9211 (Fax)

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of 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 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 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 and to carry out treatment, payment activities and health care operations. I also acknowledge that I have received a copy of this office's Notice of Privacy Practices.

SIGNATURE: _____ **DATE:** _____

*** If the patient is a child or a personal representative on behalf of the patient, complete the following:
Parent or Personal Representative's Name: _____
Relationship to the patient: _____

If you would like o give consent to a spouse, family members, etc., to access your records on your account, please add that person's name and information below.

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PATIENT INFORMATION

Name: _____ SSN: _____-_____-_____
Home Address: _____ City/Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Date of Birth: _____ Sex: _____ Male _____ Female Marital Status: _____ Single _____ Married
Patient/Parent Employer: _____ Occupation: _____
Email address: _____ Referred By: _____
Notify in case of Emergency: _____ Phone: _____
Person financially responsible for account: _____
Date of Birth: _____ SSN: _____-_____-_____

PRIMARY INSURANCE INFORMATION

Insurance Subscriber's Name: _____
Relation to Patient: _____ Date of Birth: _____ SSN: _____-_____-_____
Address (if different from patient): _____ City/Zip: _____
Home Phone: _____ Cell Phone: _____
Dental Insurance Company: _____ Business Phone: _____
Group #: _____ ID#: _____
Employer: _____ City/Zip: _____

ADDITIONAL INSURANCE INFORMATION

Is patient covered by additional dental insurance: _____ Yes _____ No
Insurance Subscriber's Name: _____
Relation to Patient: _____ Date of Birth: _____ SSN: _____-_____-_____
Address (if different from patient): _____ City/Zip: _____
Home Phone: _____ Cell Phone: _____
Dental Insurance Company: _____ Business Phone: _____
Group #: _____ ID#: _____
Employer: _____ City/Zip: _____

I hereby authorize **Gavin L. Criser, D.D.S., M.S.** to treat the above-named patient for dental problems. I am financially responsible for all services rendered. I also authorize the release of any information required to process insurance claims and request payment be sent directly to the doctor unless otherwise stated on the claim form. An estimate of benefits is RARELY exact, and disputed concerning coverage, usual and customary fee schedules, etc. are strictly between you and your insurance company. Your account remains strictly YOUR RESPONSIBILITY.

I certify that I have read and understand the above information to the best of my knowledge.

Signature of Patient (or Parent if minor):
_____ Date: _____

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Name: _____ **Date:** _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No
If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No
If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No
If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No
If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you?
◯ Pregnant/trying to get pregnant? ◯ Nursing
◯ Taking oral contraceptives?

Are you allergic to any of the following?
◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic ◯ Metal ◯ Latex
◯ Local Anesthetics ◯ Other If Yes, please explain: _____

Do you have, or have you had, any of the following?

◯ Aids/HIV	◯ Fainting	◯ Low BP
◯ Alzheimer's Disease	◯ Heart Attack	◯ Mitral Valve Prolapse
◯ Anaphylaxis	◯ Heart Murmur	◯ Pain in Jaw
◯ Anemia	◯ Heart Trouble/Disease	◯ Psychiatric Care
◯ Angina	◯ Hemophilia	◯ Radiation Treatment
◯ Artificial Heart Valve	◯ Hepatitis A	◯ Renal Dialysis
◯ Artificial Joint	◯ Hepatitis B or C	◯ Rheumatic Fever
◯ Asthma	◯ Herpes	◯ Rheumatism
◯ Cancer	◯ High BP	◯ Scarlet Fever
◯ Chemotherapy	◯ High Cholesterol	◯ Shingles
◯ Congenital Heart Disorder	◯ Hypoglycemia	◯ Sickle Cell Disease
◯ Diabetes	◯ Irregular Heartbeat	◯ Stroke
◯ Emphysema	◯ Leukemia	
◯ Epilepsy/Seizures		

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office f any changes in medical status.

Date: _____ Signature pf Patient, Parent or Guardian _____

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ENDODONTIC CONSENT & INFORMATION

We would like our patients to be informed about the various procedures involved in endodontic therapy and have their consent before starting treatment. Endodontic (root canal) therapy is performed to save a tooth which otherwise might need to be removed. This is accomplished by conservative root canal treatment or when needed, endodontic surgery. The following pertains to root canal therapy and the possible risks that may occur.

- Treatment may require multiple visits. It is important that you maintain all scheduled appointments, or the infection mar reoccur.
- In most cases, there is only mild discomfort following each treatment. This is usually controlled with Aspirin, Tylenol, Ibuprofen or Prescribed medication.
- Endodontic treatment has a high degree of success. However as with any medical or dental procedure this treatment has no guarantee or success for any length of time.
- Accurate and complete disclosure of medical information is necessary for proper diagnosis and to prevent unnecessary complications during our treatment

The most common complications with root canal therapy include, but are not limited to:

- Continued infection requiring endodontic surgery or extraction of the tooth.
- Calcified canals or canals blocked by broken instruments requiring surgery or the extraction of the tooth.
- Possible temporary and/or permanent numbness of the lip, tongue, etc. due to infection and/or needle injection.
- Pain requiring use of medication
- Side effects and reactions to medication.
- Fracture (breaking) of the root or crown during or after treatment. It is therefore, strongly recommended that all posterior teeth be crowned following root canal treatment. If your tooth already has a crown, there is a chance it will need to be replaced due to decay or loss of structural support. Porcelain crowns are subject to breakage.
- Tenderness of the tooth following treatment due to possible complications with root canal treatment, gum disease, physical stress from chewing or the degree of healing your body exhibit.

Other treatment choices include: waiting for development of definitive symptoms and/or extraction of the tooth. Risks involved with these choices might include but not limited to: pain, infection, swelling, loss of teeth and infections to other areas.

After the endodontic therapy is completed, the tooth must be restored properly. The endodontic fee DOES NOT include the fee for restoration.

If you have any questions, please ask.

Patient's Name: _____ Date: _____
Signature of Patient, Parent or Guardian: _____

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TREATMENT FEES, PAYMENT, AGREMENT & ASSIGNMENT FORM

In general, PAYMENT is due in full upon services rendered. The exceptions to this are:

1. Patients who have made prior financial arrangement due to an extended treatment plan.
2. Patients who have dental insurance, who will have to pay their part of the fee down.

Patient Name: _____ **Date:** _____

Treatment:	**Fee:**
Consultation & Examination	$ _____
X-rays	$ _____
Procedure	$ _____

PAYMENTS AGREEMENTS:

1. Payment is due in full at the time of treatment (In some cases, if applicable, insurance coverage payment is sent directly to the responsible party by the insurance company.)

Total of estimated treatment charges	$ _____
Payment due at the time of treatment	$ _____

2. Patients who have dental insurance coverage, please read:

We will file your dental insurance for you. We do this as a courtesy for you. At the time of service, you are responsible for your portion of the fee that your insurance does not cover. **We can only estimate** what this is, and **ANY** balance left over after the insurance company pays, you are responsible for.

Please be aware the there are times that the insurance company leads us to believe a service will be covered at a specific percentage, but they end up not covering it at all or covering it at a lower percentage. Reasonable and customary fees for the insurance company usually differ from those of the office and may adjust the amount coverage paid by the insurance company. **This is not the fault of the dental office and we cannot absorb the difference. You will be responsible for any and all balances due. Please remember, if you have dental insurance, this is a contractual agreement between you and your insurance company. We are not a part of this contract.**

Partial payment at the time of treatment with assignment of insurance benefits made to this office:

Total of estimated treatment charges	$ _____
Payment amount due at the time of treatment	$ _____

Payment agreement and assignment of benefits: I understand and agree that (regardless of any insurance status) I am ultimately responsible for all the above charges and any balances of my account for the professional services rendered. **If the insurance company has not paid Dr. Gavin Criser in 60 days, the balance is due in full by the responsible party**. I have read all the information on this form and certify that the insurance information is true and correct to the best of my knowledge and will notify this office of any changes on my insurance status. I hereby authorize the insurance benefits to be paid directly to **Dr. Gavin Criser**.

Signature of responsible party: _____ **Date:** _____