

New Patient Registration

ABOUT YOU

First name	Middle initial	Last name	
Street address	City	State	ZIP code
Date of birth	Sex	Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	
Home phone	Cell phone	Work phone	
May we call you at work? ☐ Yes ☐ No		Social Security # (only if needed for insurance)	
Email address	Paperless billing statements by email? ☐ Yes ☐ No		
Employer / occupation		Employer phone	
Emergency contact		Emergency contact phone	
Your general dentist	Dentist phone	Who referred you to our office?	

DENTAL INSURANCE

Name of insured person (policyholder)		Relationship to patient
Policyholder date of birth	Policyholder SSN	Insured ID #
Policyholder employer	Group #	
Insurance company	Insurance company address	Insurance phone
Do you have a second (secondary) insurance? ☐ Yes ☐ No If yes, please complete:		
Secondary insurance company		Group #
Name of insured person (policyholder)		Relationship to patient
Policyholder date of birth	Policyholder SSN	Insurance phone

RESPONSIBLE PARTY (IF PATIENT IS UNDER 18 OR A FULL-TIME STUDENT)

First name	Middle initial	Last name	
Address	City	State	ZIP
Home phone	Work phone	Date of birth	

Please complete the medical history on the back. →

Medical History

These questions help us diagnose and treat you safely. Your answers are confidential. Please let us know whenever your health or medicines change.

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Has your health changed in the past year?
If yes, please explain: | ☐ | ☐ |
| 2. Are you in good health?
If not, please explain: | ☐ | ☐ |
| 3. Are you taking any medicines or drugs?
Please list all: | ☐ | ☐ |
| 4. Do you have any allergies to foods, medicines, latex or metals?
If yes, which ones?: | ☐ | ☐ |

5. Do you have, or have you ever had, any of the following? (check all that apply)

- | | |
|--|---|
| ☐ High blood pressure | ☐ Sinus trouble |
| ☐ Heart murmur or mitral valve prolapse (MVP) | ☐ Thyroid problems |
| ☐ Joint prosthesis / replacement | ☐ Diabetes |
| ☐ Rheumatic fever or rheumatic heart disease | ☐ Stomach ulcers or irritable bowel syndrome |
| ☐ Congenital heart disease | ☐ Colitis |
| ☐ Prosthetic heart valve | ☐ Hepatitis, jaundice or liver disease |
| ☐ Blood disorder (such as anemia) | ☐ Psychiatric treatment |
| ☐ Venereal disease | ☐ Epilepsy, fainting spells or seizures |
| ☐ Asthma | ☐ Cancer |
| ☐ TMJ (jaw joint) problems | ☐ HIV/AIDS |

Have you been told to take antibiotics before dental treatment (premedicate)? ☐ Yes ☐ No

6. Do you have a pacemaker and/or defibrillator? ☐ Yes ☐ No

7. Do you have any other disease, condition or problem not listed above? ☐ Yes ☐ No

8. Women: Are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

9. Do you take birth control pills? ☐ Yes ☐ No

If you take birth control pills: antibiotics can make them less effective, so please use another method of birth control while taking antibiotics.

I understand that, as a service to me, the office will help process my insurance claims, but **I am fully responsible for all fees.** All of the information above is true to the best of my knowledge.

Signature (patient, or parent if patient is a minor)

Date

I authorize the use of my x-rays and/or photographs in seminars or publications by the doctor.

Signature (patient, or parent if patient is a minor)

Date

HIPAA Authorization Form

Your privacy and your health information

The U.S. Department of Health and Human Services created the HIPAA "Privacy Rule" to help make sure personal health information is protected. It also sets a standard for how health care providers get patient consent to use and share health information for treatment, payment, and health care operations.

HOW WE PROTECT YOUR INFORMATION

- We respect the privacy of your health records and will do all we can to keep them secure.
- We share only the minimum information needed for treatment, payment, or health care operations, as allowed by law.
- We support your full access to your own health records.
- We will keep calling to confirm appointments, give reminders, or share instructions for your visit, **unless you ask us not to.**

YOUR RIGHTS

- You may refuse to consent to sharing your personal health information (PHI), but this must be **in writing**. Under this law, we have the right to refuse treatment if you do not sign.
- If you give consent, you may later take back (revoke) all or part of it. This cannot undo actions already taken based on this or an earlier consent.
- You have the right to review our Notice of Privacy Practices, to request restrictions, and to revoke consent in writing after reviewing it.
- If you object to anything on this form, please ask to speak with our **HIPAA Compliance Officer**.

We welcome your input about any problem so we can fix it quickly.

☐ **I have reviewed the Cottonwood Endodontics, P.C. Notice of Privacy Practices.**

Patient name (please print)

Signature of patient or parent/legal guardian/representative

Date

If signed by someone other than the patient, relationship to patient

PEOPLE I ALLOW TO ACCESS MY MEDICAL INFORMATION

Name

Relationship

Name

Relationship

Fee Estimate and Payment Options

Patient name

Original date of service

Thank you for choosing our office for your endodontic treatment. Please review your fee estimate below. **Fees are due when treatment is complete.** If you have questions, please ask our front desk before treatment.

Tooth #	Treatment proposed	ADA code	Fee

Total fee

Estimated insurance payment or discount

YOUR ESTIMATED PORTION (due at time of treatment)

Save with cash or check

Prices above are card prices. **Pay in full with cash or check at the time of treatment and save 3.5%.**

ABOUT INSURANCE

This is our best estimate. Because we do not hold your insurance contract, the amount your insurance pays may be different.

Payment for endodontic services is the patient's responsibility. We cannot provide services on the assumption that insurance will pay.

LATE PAYMENTS

Cottonwood Endodontics, P.C. may charge a late fee of 18% per year on amounts not paid on time. If an account is sent to a collection agency, the patient or responsible party will be responsible for all collection fees and costs, including reasonable legal fees needed to collect the remaining balance.

I have reviewed the office financial policy and federal Truth-in-Lending statement on the back of this form.

Signature

Date

Relationship to patient

Office Financial Policy and Federal Truth-in-Lending Statement

PAYMENT ARRANGEMENTS

As a condition of treatment, financial arrangements must be made **before** treatment. Our practice depends on payment from patients to cover the cost of their care. Emergency services, and any services provided without arrangements made in advance, must be paid by cash or credit card at the time of service.

DENTAL INSURANCE

All services are charged directly to the patient, and the patient is personally responsible for payment. We will help prepare your insurance forms and help collect from your insurance company, and we will credit any insurance payments to your account. However, we cannot provide services on the assumption that insurance will pay in full.

SERVICE CHARGES

A monthly service charge of **1.5% per month (18% per year)** on the unpaid balance as of the last day of each month will be added to accounts more than **60 days** past the date of service, unless written arrangements were made in advance. Fee estimates are valid for **6 months** from the date of your exam.

MY AGREEMENT TO PAY

In return for the services provided to me (or, at my request, to my minor child or ward), I agree to pay the fees charged at the time services are provided. If my account becomes past due, I agree to pay the remaining balance plus the collection agency's fee, reasonable attorney fees, and court costs where legal services are needed. I authorize the release of financial information about my account (charges, payments, interest, etc.) to the collection agency or attorney if collection becomes necessary.

CONTACTING ME

You or your representative may call me at home or at work about matters related to this form. You may leave messages about appointments and/or results on my voicemail or with a family member.

SHARING INFORMATION WITH MY INSURANCE

I authorize the dentist or his designee to release financial information and treatment descriptions, electronically, by fax, or on paper, to my insurance carrier or any related entity that requires it.

PRIVACY

I acknowledge that I have reviewed a copy of this office's Privacy Policies. I agree to tell the dentist the names of anyone with whom I allow him to discuss my dental care.

PAYMENT POLICY: CASH DISCOUNT

Our standard prices are card prices. Patients who pay with **cash or check at the time of service receive a 3.5% discount** off the standard price. The discount is applied automatically at checkout when a qualifying payment method is used. **This is not a surcharge.** For details on how your payment information is handled by our processor, visit <https://dentalpay.ai/>.

Certification

I certify that I have answered all questions about finances accurately and to the best of my knowledge, and I agree to the conditions described above.

Consent for Root Canal Treatment

Patient name _____

Date of birth _____

Please read this form before your treatment. You will sign it before we begin, but **signing it does not commit you to treatment**. Ask us about anything that is not clear.

Procedure:

- ☐ Root canal treatment (RCT) ☐ RCT with GentleWave ☐ Other: _____

WHAT I AM AGREEING TO

I consent to the endodontic procedures indicated, and to any other procedures that are necessary or advisable as part of my planned treatment, performed by **Dr. Warren** and any assistant he may need. I agree to the use of local anesthetic (numbing medicine). I understand the doctor will talk with me before giving any sedation or nitrous oxide.

ABOUT ROOT CANAL TREATMENT

- Root canal treatment is done to save a tooth that might otherwise need to be removed. As a specialty practice, we perform only endodontic (root canal) treatment and related surgery.
- Root canal treatment has a very high success rate, but **results cannot be guaranteed**. Occasionally a treated tooth may later need retreatment, surgery, or removal.
- After treatment, the tooth may be brittle and can crack. **My general dentist will need to place a filling or crown** (and possibly a post and core) to restore the tooth.

POSSIBLE RISKS

- **From treatment and anesthetic:** swelling, discomfort, limited jaw opening (trismus), infection, bleeding, sinus involvement, and numbness or tingling of the lip, gums or tongue. Numbness is rarely long-lasting and even more rarely permanent.
- **During treatment:** a small instrument may separate (break) inside a canal; an extra opening (perforation) may occur; bridges, fillings, crowns or porcelain veneers may be damaged; canals may be missed; some tooth structure may be lost while reaching the canals; or the tooth may fracture.
- Sometimes a minor surgical procedure is needed, or the tooth cannot be treated with a root canal at all.

OTHER CHOICES

Other options include no treatment, waiting until symptoms are clearer, or removing the tooth. Risks of these choices include, but are not limited to, pain, infection, swelling, loss of teeth, and infection spreading to other areas.

MEDICINES

Medicine may sometimes be prescribed. Medicines for pain and sedation can cause drowsiness, which alcohol or other drugs can make worse. I should **not drive or operate hazardous equipment** while taking them. Some medicines can cause hives or stomach and intestinal problems. If this happens, I will call right away.

MY RESPONSIBILITIES

- Report any symptoms to the office **right away**.
- Tell the office about any changes in my medical history.

My agreement

All my questions have been answered, and I understand the statements in this form. If the patient is under 18, a parent or guardian must sign.

Patient signature (or parent/guardian) _____

Date _____

Doctor signature _____

Assistant signature _____

Consent for Endodontic Microsurgery

Patient name

Date of birth

I authorize **Roger K. Warren, DDS**, and the dental assistants who work with him, to treat the condition(s) described below:

The procedure(s) needed to treat the condition(s) have been explained to me. I understand them to be:

WHAT I AM AGREEING TO

I consent to the procedures indicated, and to any other procedures that become necessary or advisable during my planned microsurgery, performed by Dr. Warren. Dr. Warren will talk with me before giving any local anesthetic, IV sedation, or nitrous oxide.

Possible risks of microsurgery and anesthesia

Swelling, pain, sores on the gum tissue (ulceration), limited jaw opening (trismus), infection, bleeding, sinus involvement, and numbness or tingling of the lip, gum or tongue, which is rarely permanent.

A sinus fistula (opening) could result, and sinus drainage surgery might be needed if an infection develops.

I will report any symptoms to Dr. Warren right away.

MEDICINES

Dr. Warren may prescribe medicine. Medicines for pain and sedation can cause drowsiness, which alcohol or other drugs can make worse. I should **not drink alcohol, drive, or operate hazardous equipment** while taking them. Some medicines can cause hives or stomach and intestinal problems. If this happens, I will call Dr. Warren right away. I will tell Dr. Warren about any changes in my medical history.

I ALSO UNDERSTAND THAT

- A perfect result is **not guaranteed**.
- I have had the chance to ask the doctor about the treatment, its risks, and the alternatives.
- This form does not cover everything I discussed with the doctor or assistant.
- I give permission to take video, x-rays and photographs of my mouth and teeth for teaching and educational purposes.

QUESTIONS

If anything about the procedure or this form is unclear, or you still have questions after talking with the doctor, please write them below. If you have no questions, write **"NONE."**

Dr. Warren

Patient signature (parent/guardian if under 18)

Date

Doctor

Assistant

Consent for IV Sedation

IV sedation / anesthesia

Patient name

Date of birth

Please read this form carefully and ask us about anything that is not clear. **I understand that IV sedation/anesthesia has possible risks, including but not limited to:**

1 Side effects of medicines and anesthesia.

Tenderness, bruising, nausea, vomiting, swelling, bleeding, infection, numbness, allergic reaction, stroke, and heart attack. **Some of these, although rare, may require hospital care and could even result in death.**

2 Bruising or tenderness where the IV is placed.

Some sedatives may cause burning or itching in the wrist or arm when they start. If IV fluid leaks into the surrounding tissue, swelling (edema) may take several days to go away. Warm, moist heat on the area helps.

3 Limits on food and drink.

Morning appointment: no food or drink after midnight.

Afternoon appointment: a light breakfast no later than 6 hours before treatment, and clear liquids until 3 hours before.

4 Changes in my health.

I will tell the dentist before my appointment about any change in my health, including a fever or cold.

5 A responsible adult must take me home.

I must not drive, or take a bus or taxi, after IV sedation/anesthesia.

6 Pregnancy.

Anesthetics, medicines and drugs may harm an unborn child and may cause birth defects or miscarriage. I am responsible for telling the dentist or anesthesia provider if I am, or may be, pregnant.

Informed consent

I have had the chance to ask questions about the nature and purpose of IV sedation/anesthesia, and they were answered to my satisfaction. I voluntarily accept the possible risks, including serious harm or death, that may come with any part of IV sedation/anesthesia, in hopes of the desired results, which may or may not be achieved. No guarantees or promises have been made about my recovery or the results of treatment. The fees for this service have been explained to me and are acceptable.

By signing, I freely consent to and authorize Dr. Warren and his associates to provide any treatment necessary or advisable for my dental condition, including any anesthetics and/or medicines, for my own benefit or the benefit of my minor child or ward.

Signature of patient, parent/guardian, or authorized representative

Date

Witness signature

Date

Oral Sedation: Information and Consent

Triazolam (Halcion)

Patient name

Date of birth

Triazolam (Halcion) is usually prescribed as a sleeping pill, but it can also greatly reduce the anxiety some people feel about dental visits. You will be relaxed, but still able to talk with the dentist during treatment. It is safe and effective and wears off quickly, but please read these important precautions.

1 Sign before you take the pill.

This form and your treatment consent form must be signed **before** you take the medicine. They are not valid if signed afterward.

2 Eat lightly beforehand.

Do not eat a heavy meal. You may take the medicine with a small amount of food, such as juice or toast. Too much food makes it hard to predict how the medicine will work.

3 Know how it works.

It starts working in 15 to 30 minutes and is strongest after 1 to 2 hours. Most people feel normal after 6 to 8 hours. Nitrous oxide may be used along with triazolam and local anesthetic. If you smoke, the medicine will probably work less well.

4 Possible side effects.

Light-headedness, headache, dizziness, vision changes, memory loss (amnesia), and nausea. In some people, the medicine may not work as hoped.

5 Do not drive for the rest of the day.

Do not drive after taking the medicine. Because people react differently, do not drive or use machinery for the rest of the day. Wait until tomorrow.

6 Getting home safely.

Ride home with your car seat reclined. At home, lie down with your head slightly raised. Someone should stay with you for the next several hours, because you may feel confused and could fall.

DO NOT TAKE THIS MEDICINE IF YOU:

- Are sensitive to benzodiazepines (such as Valium, Ativan or Versed)
- Are pregnant or breastfeeding
- Have liver or kidney disease

TELL THE DOCTOR IF YOU TAKE:

- Nefazodone (Serzone) or cimetidine (Tagamet, Tagamet HB, Novocimetine, Peptol)
- Levodopa (Dopar, Larodopa) for Parkinson's disease
- Antihistamines (such as Benadryl or Tavist)
- Verapamil (Calan) or diltiazem (Cardizem)
- Erythromycin, clarithromycin (Biaxin), or azole antifungals (Nizoral, Sporanox)
- HIV drugs indinavir or nelfinavir
- Alcohol. Recreational or illegal drugs can also cause serious reactions.

My agreement

I understand these precautions and agree to follow them. I have had the chance to ask questions, and they were answered to my satisfaction.

Patient signature

Date

Parent/guardian signature (if under 18)

Preparing for Your IV Sedation Appointment

Please read these instructions before your visit

You are scheduled for root canal (endodontic) treatment using **IV sedation** together with **local anesthetic** (numbing medicine). Discomfort afterward is usually mild and easy to control with medicine. We will give you written aftercare instructions at your appointment.

Arrange a ride before your visit

An adult must **drive you home** and **stay with you for a few hours** after your appointment.

BEFORE YOUR APPOINTMENT

1 Do not eat or drink anything for 6 hours before your appointment.

2 Keep taking your regular medicines.

Continue medicines for blood pressure, thyroid and other conditions as your physician recommends. If you have diabetes, ask your physician when to take your medicines. Questions? Please call us before your appointment.

3 Take antibiotics first, if you have been told to.

If your physician or dentist told you to take an antibiotic before dental care (for example, for mitral valve prolapse, a heart murmur, a hip, knee, heart or other prosthesis, or past rheumatic heart disease), make sure you take it on the day of your appointment. Please call if you have questions.

4 Consider taking an anti-inflammatory the day before.

If you can safely take ibuprofen or naproxen, starting it before your visit helps reduce swelling and pain afterward. The day before your appointment, take:

- **Advil** (ibuprofen 200 mg): 4 tablets every 6 hours, **or**
- **Aleve** (naproxen 220 mg): 2 tablets every 12 hours

Stop 6 hours before your appointment, when you also stop eating and drinking.

5 Wear comfortable clothes with short sleeves.

This lets us place your IV and blood pressure monitor easily.

We look forward to seeing you!

After Your Root Canal Treatment

What to expect and how to care for your tooth while it heals

Your root canal treatment is complete. The inside of the root is now permanently sealed. The top of the tooth has a **temporary filling**.

Important: your next step

Call your general dentist **right away** to schedule a permanent filling or crown. Without it, the tooth can break or decay, and the root canal may need to be redone.

We will send a full report of your treatment to your dentist.

WHAT IS NORMAL

- Your tooth and the gum around it may be **tender**, especially when you bite.
- This gets better as the tissues around the tooth heal.
- Healing is different for everyone. It can take **up to 6 months** to heal completely.

MANAGING DISCOMFORT

You may take **one** of these over-the-counter pain relievers:

Medicine	Strength	How much	How often
Ibuprofen (Advil, Motrin)	200 mg tablets	1 to 4 tablets (200 to 800 mg)	Every 6 hours
Naproxen (Aleve)	220 mg tablets	1 to 2 tablets	Every 12 hours
Acetaminophen (Tylenol)	500 mg tablets	1 to 2 tablets	Every 6 hours

Call us right away at 801-278-3636 if:

- Pain is not controlled by the medicines above
- Swelling develops
- You are not sure whether what you are feeling is normal

Please have your **pharmacy's phone number** ready when you call.

YOUR FOLLOW-UP VISIT

Most root canal treatments heal very well. Once in a while a problem develops, so we like to check how your tooth is healing. Your treatment **includes a short follow-up exam at no extra charge**. It only takes a few minutes.

Please call us during this month to schedule it: _____

Thank you for trusting us with your care. If you have questions or problems, you are always welcome to call.

After Your Endodontic Microsurgery

Care instructions for the first few days

FOR THE FIRST 24 HOURS, PLEASE DON'T:

- **Rinse your mouth** for the first 12 hours
- **Exercise.** It can cause bleeding and swelling.
- **Smoke**
- Eat **crusty, hard or hot** foods
- **Lift or pull your lip** to look at the area. This can tear the tissue and slow healing.

WHAT IS NORMAL

- **Slight swelling** and some bruising or color change on the skin
- A **small amount of bleeding** for the first 24 hours
- **Mild discomfort**

TO REDUCE SWELLING

Hold an ice pack on your face over the surgery area with gentle pressure. **20 minutes on, 10 minutes off.** Repeat for 1 to 2 hours.

FOR DISCOMFORT

If you were given a prescription, take it exactly as directed. **Avoid aspirin** and any medicine that contains aspirin.

EATING AND DRINKING

Getting enough food and fluids is very important. **Soft, cold foods are best**, such as ice cream, gelatin, pudding and yogurt. If eating is hard, try a meal replacement drink such as Instant Breakfast.

KEEPING THE AREA CLEAN

- **After 12 hours**, gently rinse with warm salt water ($\frac{1}{2}$ teaspoon of salt in 1 cup of warm water) after each meal and at bedtime. Keep doing this until your stitches are removed.
- Avoid mouthwashes that contain alcohol, such as Listerine and Scope.
- Brush your other teeth carefully with a soft toothbrush. **Do not brush the surgery area** until your stitches are removed.
- **Do not floss** the surgery area.

SLEEPING

The first night, sleep with your head slightly raised (an extra pillow helps).

Call us right away at 801-278-3636 if you have:

Heavy bleeding, increasing swelling, fever, or anything else that seems unusual.

YOUR FOLLOW-UP VISIT

We will remove your stitches and check your healing on:

Date

Time

If you have any questions, please call.

After Your Microsurgery Is Complete

How to care for the area while it finishes healing

Your endodontic microsurgery is complete. Here is what to expect and how to keep the area healthy while it heals.

WHAT IS NORMAL

- The tooth may be **tender when you bite or chew**. This gets better as the tissues heal.
- Healing is different for everyone. It can take **up to 6 months** to heal completely.

BRUSHING, FLOSSING AND CHEWING

- You can start brushing, flossing and chewing on that side again. **Go gently.**
- Brushing or flossing too hard can damage the healing tissue.

If cleaning causes pain or bleeding:

1. Stop cleaning that area.
2. Rinse with warm salt water 3 to 4 times a day (½ teaspoon of salt in 1 cup of warm water).
3. Wait a few more days, then try cleaning the area again.

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