Andrew R. Lulloff D.D.S., S.C.

PATIENT INFORMATION AND HISTORY

PRACTICE LIMITED TO ENDODONTICS

Name: _____ Single _____ Divorced _____
Last First Middle Initial Married _____ Separated _____
Age _____ Birthdate _____ Sex _____ Widowed _____

Address _____
Number Street City State Zip Code

Social Security _____ Email _____ Cell Phone ( ) _____

Occupation _____ Employer _____ Home Phone ( ) _____

Spouse's Name _____ Employer _____ Work Phone ( ) _____

Referred By _____ Dentist _____ Physician _____

EMERGENCY CONTACT:

Name: _____ Phone _____ Relationship _____
Last First Initial

Address _____
Number Street City State Zip Code

IF PATIENT IS A CHILD OR STUDENT FILING PARENT'S INSURANCE:

If you (the patient) are a student, what school do you attend? _____
Name of School City State Zip Code

Father's Name _____ Address (if different) _____

Father's Date of Birth _____ Home Phone ( ) _____

Employer _____ SS# _____ Work Phone ( ) _____

Mother's Name _____ Address (if different) _____

Mother's Date of Birth _____ Home Phone ( ) _____

Employer _____ SS# _____ Work Phone ( ) _____

PRIMARY INSURANCE:

Policy Holder _____ Employer _____

Dental Company _____ Group # _____

_____ Member ID # _____

Subscriber's Birth Date _____ Social Security # _____

SECONDARY INSURANCE:

Policy Holder _____ Employer _____

Dental Company _____ Group # _____

_____ Member ID # _____

Subscriber's Birth Date _____ Social Security # _____

Please see back side for additional questions ☛

Patient Information and History for: _____

Reason for today's visit _____

Is the reason for your visit today due to an accident? ..... Yes _____ No _____

Date of injury: _____

_____

Weight_____ Height_____ What is the state of your general health? _____

1. Are you under any medical treatment now? ..... Yes _____ No _____
2. Are you taking any drugs or any medication now? ..... Yes _____ No _____

   Please list medications (including over the counter weight reduction medications)

_____ _____

_____ _____

_____ _____

_____ _____

3. Have you had any major operations recently? If so what?_____ ..... Yes _____ No _____
4. Do you have any artificial joints/hip replacements/body parts? ..... Yes _____ No _____
5. Have you or your relatives had a bad reaction to anesthesia? ..... Yes _____ No _____
6. Have you ever had any adverse reactions to drugs? (Penicillin, etc.) ..... Yes _____ No _____
7. Are you allergic to any materials? If so what?_____ ..... Yes _____ No _____
8. Have you ever had a serious accident involving head injuries? ..... Yes _____ No _____

   If so when?_____

9. Have you ever been told that you had:
   - Seizures or nervous disorder? ..... Yes _____ No _____
   - A heart disorder? ..... Yes _____ No _____
   - A lung disorder? (asthma, emphysema, T.B.) ..... Yes _____ No _____
   - High/low blood pressure? ..... Yes _____ No _____
   - Rheumatic fever? ..... Yes _____ No _____
   - Diabetes? ..... Yes _____ No _____
   - Tumors or growths? ..... Yes _____ No _____
   - Any glaucoma, increased eye pressure? ..... Yes _____ No _____
   - Any blood disease? (bleeding problems, anemia) ..... Yes _____ No _____
   - Any liver disease? (hepatitis, mono) ..... Yes _____ No _____
   - Any kidney disease? ..... Yes _____ No _____
   - Any stomach or intestinal disease? ..... Yes _____ No _____
   - Any sexually transmitted disease? ..... Yes _____ No _____
10. Do you/did you abuse alcohol or drugs? ..... Yes _____ No _____
11. Have you had or do you have poor wound healing? ..... Yes _____ No _____
12. Have you had any recent loss or gain in weight? ..... Yes _____ No _____
13. Are you on any special diet at this time? ..... Yes _____ No _____
14. Do you have a history of fainting? ..... Yes _____ No _____
15. Have you had any abnormal oral bleeding? ..... Yes _____ No _____
16. Do you smoke or use tobacco? How much? ..... Yes _____ No _____

16a. If you quit smoking/using tobacco when did you quit?_____ How much did you smoke/use?_____

17. (Female) Are you or could you be pregnant? ..... Yes _____ No _____
18. Do you take birth control pills? ..... Yes _____ No _____

I hereby confirm that the above facts are true to the best of my knowledge.

Signature_____ Date _____

Andrew R. Lulloff D.D.S., S.C. AUTHORIZATION

PRACTICE LIMITED TO ENDODONTICS

Purpose: This form is used for an individual to authorize use or disclosure of the individual's protected health information for the purposes stated.

SECTION A: Individual authorizing use and/or disclosure (may use patient sticker).

Name: _____

Address: _____

Phone: _____ Medical Record Number: _____

TO THE INDIVIDUAL: Please read the following and complete the information requested.

No Conditions: This authorization is voluntary. We will not condition your treatment on receiving this authorization.

Effect of Granting this Authorization: The protected health information described below may be disclosed to and/or received by persons or organizations who are not subject to federal health information privacy laws. These persons or organizations may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws.

SECTION B: To whom the information is being authorized for release to:

Name: _____

Address: _____

Phone: _____ Relationship to Patient: _____

SECTION C: The use and/or disclosure being authorized.

Purpose of this Authorization:

- ❑ Appointment Information – including dates, times, and provider's name
- ❑ Financial Information
- ❑ Lab Results
  List, if there are specifics: _____
- ❑ Diagnostic tests
  List, if there are specifics: _____
- ❑ Can leave message on answering machine
- ❑ Can fax information to fax #: _____
- ❑ Can email information to: _____
- ❑ Other: _____

_____

SECTION D: Expiration and revocation.

Expiration: This authorization will expire (complete one):

- ❑ On _____ /_____ /_____
- ❑ Until I choose to revoke it.

Right to Revoke: You may revoke this authorization at any time by providing verbal or written notice of revocation to Andrew R. Lulloff D.D.S., S.C. by calling (920) 593-2569 or sending it to Andrew R. Lulloff D.D.S., S.C., Attn: Privacy Official, 2981 Voyager Drive, Green Bay, WI 54311. Revocation of this authorization will not affect any action we took in reliance on this authorization before we received your verbal or written notice of revocation.

CONTINUED ON BACK

INDIVIDUAL'S SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use and/or disclosure of my protected health information, as described in this form.

Signature:_____ Date:_____

If a personal representative on behalf of the individual signs this authorization, complete the following:

Personal Representative's Name: _____

Relationship to Individual:_____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

Include this authorization in the individual's records.

Verbal Authorizations Obtained:

Andrew R. Lulloff D.D.S., S.C.

PRACTICE LIMITED TO ENDODONTICS

RESPONSIBILITY FOR PAYMENT

PATIENT NAME: _____

I agree to be and am fully responsible for total payment of services performed including any amounts not covered by any dental insurance, I may have.

I understand that the parent who requests treatment and/or presents a minor child for treatment is responsible for all fees for services rendered. In case of divorce, any arrangements made through a divorce agreement are strictly between the parents and do not involve the clinic.

I understand that clinic bills are due at the time of service regardless of any insurance coverage. Insurance is designed to reimburse the policy-holder and is a contract between the policyholder and the insurance company. The clinic has an insurance department and will do all it can to help collect legitimate claims. In the event the insurance company is slow to pay; reduces payment because in their estimation the charges are over usual and customary; or for some reason disallows the claim, I understand payment of the account is my responsibility.

(IF INSURED) I authorize the release of information including records and x-rays requested by my insurance company for the purpose of determining pre-treatment estimates, precertification or payment of insurance benefits. A copy of this authorization shall be as valid as the original.

_____ _____

Signature of Patient or Parent/Guardian Requesting Care Date

If guardian responsible for payment is other than parent:

Name: _____ Relationship: _____

Address: _____ Phone:( ) _____

Andrew R. Lulloff D.D.S., S.C.
PRACTICE LIMITED TO ENDODONTICS

Authorization and Consent for Endodontics Procedure

I, _____, have been advised by my referring dentist that I require root canal treatment on tooth #_____ and I request and authorize Dr. Andrew R. Lulloff to perform the root canal.

I understand that the root canal treatment is an attempt to save my tooth due to loss of vitality from infection, decay, crack, or to obtain sufficient retention for resorption. The alternative to root canal treatment is extraction.

I have discussed the root canal procedure with my dentist and I understand that the following risks and complications may arise.

1. Root canal treatment requires anesthesia and multiple radiographs (x-rays).
2. Local anesthesia injection sometimes causes trismus (difficulty in jaw opening) or paresthesia (temporary or permanent loss of sensation).
3. Postoperative discomfort or swelling, lasting a few hours to several days for which medications will be prescribed if deemed necessary by the dentist.
4. Allergic reactions to medication or anesthetics.
5. Separation of root canal instruments during treatment which may, in judgment of the dentist, be left in the treated root canal or require surgical procedure for removal.
6. Perforation of the root canal due to curved roots or existing conditions. This may require additional surgical treatment or extraction.
7. Premature tooth loss may result from cracks or fractures that can occur during the root canal treatment or from progressive periodontal gum disease.
8. Access through a crown or bridge (existing restorations) may result in damage to restorations, which is not the responsibility of this office.
9. Treatment may be discontinued due to calcified canals, separation of root canal instruments or reamers, or fracture of root or crown.
10. Success rate of root canal treatment is approximately 93%. (If failure occurs, the treatment may have to be redone, surgerized, or extracted.)
11. Post-surgical complications include: discomfort and pain, swelling, bruises, excessive bleeding, trismus, and injury to the nerve underlying the teeth which may result in numbness or tingling of the lip, chin, gums, or tongue on the operated side. This may persist for several weeks, months, or in remote instances, permanently. Also, there may be exposure of the sinus in the upper teeth.
12. The crown of the tooth may darken eventually and/or become brittle due to loss of vitality. We recommend placement of a crown or any other proper restoration determined by your referring dentist as soon as possible.

I understand that at any time during treatment, common medications may be prescribed that may have side effects such as nausea and diarrhea. If any adverse side effects such as itching, rash or hives occur, I am to stop the medication and call the dentist who prescribed them.

I understand that failure to continue with initiated treatment may result in the eventual loss of the tooth through decay, fraction, or extraction. If this occurs, I cannot hold the dentist who initiated the treatment responsible.

I understand that doing root canal therapy through crowns may hide existing decay or cracks, that are not visible to the dentist, and therefore, I cannot hold the dentist responsible for missing them.

I understand that after my root canal treatment is completed I should continue my treatment by placing a proper restoration on the tooth.

The undersigned certifies that he/she has read and is willing to comply with the foregoing, and is the patient, *the parent with authority to give consent*, or guardian of the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Date_____ Signed Name_____

Andrew R. Lulloff D.D.S., S.C.

PRACTICE LIMITED TO ENDODONTICS

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full-length Notice is available at the front desk, or by contacting the office manager.

This information is made available on request by a patient.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. REVIEW IT CAREFULLY.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices):

- ▲ For medical treatment
- ▲ To obtain payment for our services
- ▲ In emergency situations
- ▲ To run our Practice more efficiently and ensure all our patients receive quality care
- ▲ For workers' compensation programs
- ▲ To avert a serious threat to health or safety
- ▲ For appointment and patient recall
- ▲ In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- ▲ The right to inspect and copy
- ▲ The right to amend
- ▲ The right to an accounting of disclosures
- ▲ The right to request restrictions
- ▲ The right to a paper copy of this notice
- ▲ The right to request confidential communications

For more information about these rights please see the detailed Notice of Privacy Practices which may be obtained from the front desk, our office manager, or www.bayoralsurgery.com.

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I have received a copy of Andrew R. Lulloff D.D.S.,S.C.'s Notice of Privacy Practices.

Patient Name Printed	Date
Patient Signature	Authorized Provider Representative
Parent/Guardian or Personal Representative	Parent/Guardian or Personal Representative Signature

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)