Tangredi Endodontics, P.C.
1100 Franklin Avenue, Suite 302, Garden City, NY 11530 | PH: (516)746 -3636 | Fax: (516)746-0270
6306 Jericho Turnpike, Commack, NY 11725 | PH: (631) 462-6888

Welcome to Our Practice!

Date:_____

Patient Name: _____ _____ _____ _____
Last First MI Preferred

Gender: __ Male __ Female Family Status: __ Married __ Single __Child __ Other

Birth Date: _____
If under 18 years old, please provide guardian information below:
Guardian name: _____ Date of Birth: _____

Guardian phone number: _____

Email Address: _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext. Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip

Dental Information

General Dentist Name: _____

General Dentist Address: _____

General Dentist Phone Number: _____

Pharmacy Information

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

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Medical History

Indicate which of the following currently apply. By Checking the box, it will indicate a "Yes" response, leaving it blank will indicate a "No" response.

☐ Pre-Med Amox	☐ Pre-Med Clind	☐ Pre-Med Other	☐ A-FIB
☐ Allergy-Aspirin	☐ Allergy-Codeine	☐ Allergy-Erythro	☐ Allergy-Hay Fever
☐ Allergy-Latex	☐ Allergy-Lidocaine	☐ Allergy-Other	☐ Allergy-Penicillin
☐ Allergy-Sulfa	☐ Allergy-Clind	☐ Anemia	☐ Arthritis
☐ Artificial Joints	☐ Asthma	☐ Blood Disease	☐ Cancer
☐ Dizziness	☐ Epilepsy	☐ Excessive Bleeding	☐ Fainting
☐ Glaucoma	☐ Head Injuries	☐ Heart Disease	☐ Heart Murmur
☐ Hepatitis	☐ High Blood Pressure	☐ HIV	☐ MCTD
☐ Mental Disorders		☐ Nervous Disorders	☐ Other
☐ Pacemaker	☐ M.S.	☐ Radiation Treatment	☐ Respiratory Problems
☐ Rheumatism	☐ Pregnant		☐ Tuberculosis
☐ Venereal Disease	☐ Sinus Problems	☐ Stroke	☐ Diabetes

If any condition or alerts selected above needs further clarification, please explain below:

_____

_____

Are there any other medical conditions, not listed above, that we need to be aware of?

_____

_____

Describe any current medical treatment, impending surgery or other treatment that may possibly affect your dental treatment:

_____

_____

List all medications taken within the last year:

_____

_____

I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.

Signature_____ **Date:** _____

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Insurance Information

Primary Dental Insurance:
Do you have any dental insurance? _____ Yes _____ No
Are you the policy Holder? _____ Yes _____ No
Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____

ID#: _____ Group #: _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip

Patient's relationship to insured: _____ Self _____ Spouse _____ Child _____ Other

Insured's Employer Name: _____

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip

Secondary Dental Insurance:
Do you have any dental insurance? _____ Yes _____ No
Are you the policy Holder? _____ Yes _____ No
Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____

ID#: _____ Group #: _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip

Patient's relationship to insured: _____ Self _____ Spouse _____ Child _____ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____

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-Insurance Financial Agreement-

I, the undersigned patient, hereby authorize the undersigned provider to perform the procedure(s) or course(s) of treatment discussed at the time of my appointment. I understand my dental condition and will discuss several treatment options with the undersigned provider.

I understand that the FINAL Insurance Payment is based on many factors, which could result in a payment that is different from the amounts estimated. It has been explained to me that if my yearly insurance maximum has been reached, my insurance payment could be lower than the estimated payment or result in no payment at all.

I further understand that the **insurance estimate** does not take into account any deductions or any outstanding claims not yet processed. The estimated Patient Payment MUST be paid prior to completion of treatment.

I assume full financial responsibility for my account balance, including any amounts not payable by my dental insurance. I agree that I must pay any outstanding balance at the completion of my treatment. Accepted payment methods include: Cash, Check, Visa, MasterCard, Discover, American Express, and CareCredit.

I have read, agree to and understand the statements listed above.

Signature: _____
Date: _____

-Financial Agreement-

I, the undersigned patient, hereby authorize the undersigned provider to perform the procedure(s) or course(s) of treatment discussed at the time of my appointment. I understand my dental condition and will discuss several treatment options with the undersigned provider.

I understand that all dental services are charged directly to the patient and that I am responsible for payment of all dental services rendered at the time of the treatment.

The office will help prepare the insurance forms or assist in making collections from insurance companies.

I assume full financial responsibility for my account balance. I agree that I must pay any outstanding balance at the completion of my treatment. Accepted payment methods include: Cash, Check, Visa, MasterCard, Discover, American Express, and CareCredit.

I have read, agreed to and understand the statements listed above.

Signature: _____
Date: _____

-Financial Policy-

In the event that endodontic treatment is started and not completed, I, the undersigned patient agrees to pay half of the treatment fee. Refunds will be left to the discretion of the Office Manager.

I have read, agreed to and understand the statement listed above.

Signature: _____
Date: _____

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HIPAA Notice

Please be aware that this office complies with federal and state laws governing the protection of your privacy information. We strongly guard this information which is only released to an authorized individual upon your written consent or designees. All information is kept completely confidential and is only used for the treatment of your dental care.

We will attempt to contact you directly to give you important health information that is concerning your treatment, however, you may wish to designate an individual who may receive and discuss this information when it is inconvenient for you to do so yourself.

Please use this form to designate someone and indicate a designee(s) who may receive information on your behalf. Also, please be aware that you may change this information at any time in writing.

Thank you for your trust and cooperation.

I hereby designate the following individual(s) to receive and discuss my dental care information.

Name:_____Relationship:_____Phone Number:_____

Name:_____Relationship:_____ Phone Number:_____

Patient Name:_____

Signature:_____

Date: _____

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Electronic Communication Consent

I, _____, give Tangredi Endodontics PC, permission to send me electronic communications via email and/or text regarding appointments, billing and insurance.

Text messaging: Yes □ No □ Initials _____

Emails: Yes □ No □ Initials _____

I acknowledge that I am responsible for providing the dental practice with any updates to my email address or cell phone number. I am able to receive information electronically and via text and store it securely away from any public computer or cell phone. I can withdraw my consent to electronic communications at any time by calling (516)746-ENDO(3636)/(631)462-6888.

_____ _____

Patient Signature Date

Credit Card Information (Optional)

Tangredi Endodontics PC, is equipped with the latest payment technology and a paperless office. This enables us to make payments efficiently and without unnecessary paper.

Please store your credit information on file with us so we can conveniently charge account balances without burdening you.

Name on card: _____

Credit Card Number: _____

Expiration Date: _____

CVV: _____/Billing Zip Code:_____

By signing below, I am giving Tangredi Endodontics PC, permission to charge my credit card when I have a remaining responsibility. I acknowledge that I am responsible for providing the dental practice with any updates to my credit card. I can withdraw my consent to having Tangredi Endodontics PC charging my credit card at any time by calling (516)746-ENDO(3636)/(631)462-6888.

_____ _____

Patient Signature Date

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Consent Form for Endodontic Procedures

Recommended treatment and any such additional procedure(s) may be considered necessary for my well- being based on findings made during the performance of procedures. Although the Recommended Treatment has a very high success rate, it is a biological procedure and cannot be guaranteed. Occasionally, a tooth which has had root canal treatment may require retreatment, additional surgery such as an apicoectomy, or extraction.

The following discusses possible risks involved with endodontic therapy and other treatment choices.

These potential risks and complications, include, but are not limited to, the following:

- Instrument breakage in the root canal.
- Inability to negotiate canals due to prior treatment or calcification.
- Pain, infection and swelling.
- Difficulty opening and closing.
- Temporomandibular Dysfunction resulting in jaw pain.
- Nerve injury resulting in temporary or permanent numbness, itching, burning or tingling of the lip, chin, tongue or teeth.
- As a result of the injection or use of anesthesia, there may be swelling, jaw muscle tenderness or even resultant numbness of the tongue, lips, teeth, jaws and/or facial tissues, which is typically temporary, but in rare instances, may be permanent.
- Perforation to the outside of the tooth.
- Irreparable damage to the existing crown or restoration.
- Cracking or fracturing of the root or crown of the tooth.

I, _____, being the patient, parent or guardian of the patient, consent to the performance of procedures decided upon as necessary or advisable in the opinion of the doctor. I also understand that upon completion of any endodontic treatment in this office I should return to my referring dentist for the final restoration. I acknowledge that I as the patient, parent or guardian is responsible for any and all restoration procedures.

_____

(Patient/Parent or Guardian Printed Name/Date)

_____

(Patient/Parent or Guardian Signature/Date) (Witness Signature/Date)